

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12001

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARK ANTONIO NEWMAN</b>		2. Date of Death Month <b>APRIL</b> Day <b>08</b> Year <b>1996</b>		3. Time of Death <b>8:15 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>18610 MEADOWLAND TERRACE</b>		4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>217-02-1499</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>29</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 23, 1967</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Olney</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>18610 Meadowland Terrace</b>		10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 yrs</b> College (1-4 or 5+) <b>2 yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Graphic Artist</b>		16b. Kind of Business/Industry <b>Design of the Times</b>	
	17. Father's Name (First, Middle, Last) <b>Lawrence D. Newman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy J. Gray</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy J. Banks (Mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18610 Meadowland Ter., Olney, MD 20832</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 4/13</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>	
	21. Signature of Funeral Service Licensee <i>George K. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hanging</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of):					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>4-8-96</b>		28b. Time of Injury <b>UNK</b> M	
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Self-hanged self</b>	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>18610 Meadowland Terr.</b>	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier <i>John A. L. Brown MD</i>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>APRIL 09, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. L. Brown, MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature <i>John A. L. Brown</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

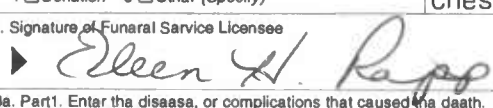
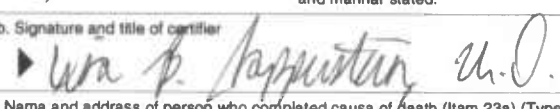
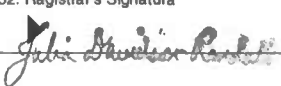


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12002

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Obrams</b>		2. Date of Death Month <b>April</b> 9, 1996 Year <b>1996</b>		3. Time of Death <b>9:50 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>402 Hurley Avenue, #302</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>577-58-5956</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 21, 1907</b>		9. Birthplace (State or Foreign Country) <b>Latvia</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>402 Hurley Avenue, #302</b>		10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Title Examiner</b>		16b. Kind of Business/Industry <b>Title Company</b>
	17. Father's Name (First, Middle, Last) <b>Janis Obrams</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Emilija Turks</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Gunta Iris Obrams</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13408 Valley Drive, Rockville, MD 20850</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>4-11-96 Beltsville, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Gastric Lymphoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>7 months</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>DC 17452</b>		29d. Date signed (Month, Day, Year) <b>April 10, 1996</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lisa B. Sapperstein, M. D.,</b>		<b>5410 Connecticut Avenue, NW, #103 Washington, DC 20015</b>		
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

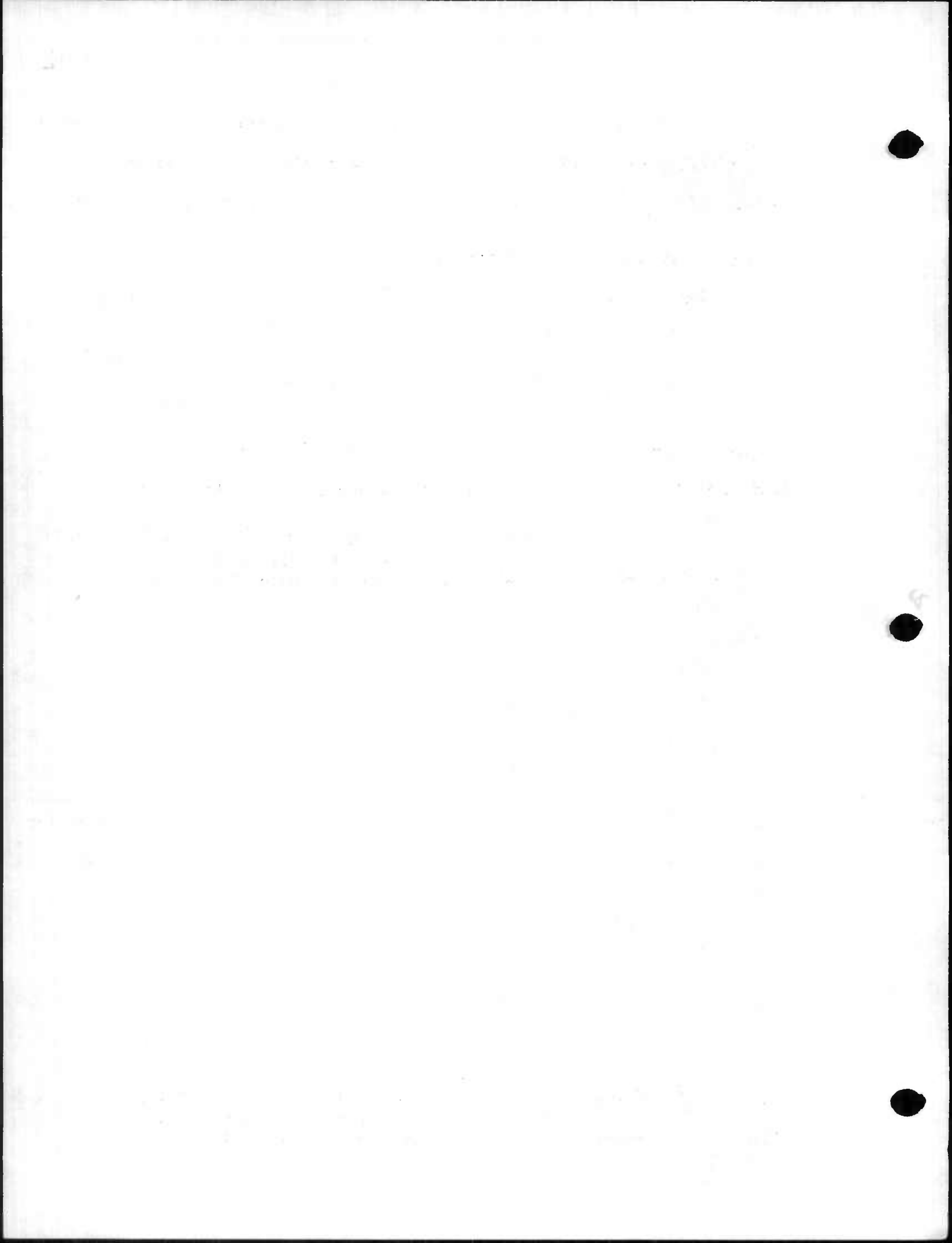
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12003

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Lillian Pautz				2. Date of Death Month Day Year April 2, 1996				3. Time of Death 6:20 a.m.					
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent					
Funeral Director	5. Social Security Number 056-22-4346		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) September 29, 1911		9. Birthplace (State or Foreign Country) New York State	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 415 Morgnac Road				10f. Zip Code 21620				10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk				16b. Kind of Business/Industry Retail					
	17. Father's Name (First, Middle, Last) Jack Plummer				18. Mother's Name (First, Middle, Maiden Surname) Anna Meade									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Laurie Crossley/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Country Club Lane, Chestertown, Maryland 21620									
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center/April 2, 1996				20c. Location - City or Town, State Chester, Maryland					
	21. Signature of Funeral Service Licensee <i>Larry B. Fellows</i>				22. Name and Address of Facility Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620									
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. ISCHEMIC BOWEL Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												Approximate Interval Between Onset and Death 24 hrs.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEMIPLEGIA DUE TO CEREBROVASCULAR ACCIDENT												23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Helen Noble MD</i>				29c. License number D41587		29d. Date signed (Month, Day, Year) 4/2/96			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Helen Noble, MD, 122 Speer Road, Chestertown, Maryland 21620													
	31. Date filed (Month, Day, Year) APR 03 '96				32. Registrar's Signature <i>John Davidson-Randall</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



## Certificate of Death

Reg. No.

96 12004

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Madeline Pierce

2. Date of Death

Month Day Year  
April 6, 1996

3. Time of Death

4:55 a.m.

4a. Facility Name (If not institution, give street and number)

Magnolia Hall Nursing and Convalescent Home

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

212-36-7830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
September 26, 1910

9. Birthplace (State or Foreign Country)

Cecil County, MD

Usual Residence of Decedant

10a. State  
Maryland10b. County  
Cecil

10c. City, Town or Location

Cecilton, Maryland 21913

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

233 West Main Street

10f. Zip Code

21913

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Clarence A. O'Neal

18. Mother's Name (First, Middle, Maiden Surname)

Theresa F. George

19a. Informant's Name/Relationship (Type, Print)

Theresa ~~Roberts~~ Rhoades

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

241 W. Main Street, Cecilton, Maryland 21913

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Dennis Cemetery/April 9, 1996 Galena, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helffenbein & Newman Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 21620

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic cardiovascular disease*

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*Several years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Carcinoma of the colon - multiple**Circumstances*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D00354

29d. Date signed (Month, Day, Year)

April 9, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C. Gottfried Baumann, MD., 100 Brown Street, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

APR 15 '96

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edmund Alphonsus Purdy, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 15, 1996		3. TIME OF DEATH 0800 A. M.	
4. SOCIAL SECURITY NUMBER 578-03-5059		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 31, 1919	
9a. FACILITY NAME (If not institution, give street and number) 4459 Three Notch Road				9b. CITY, TOWN OR LOCATION OF DEATH Mechanicsville		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Mechanicsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4459 Three Notch Road				10f. ZIP CODE 20659		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Edmund Alphonsus Purdy, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Ogen			
19a. INFORMANT'S NAME (Type/Print) Gladys V. Purdy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4459 Three Notch Road, Mechanicsville, Maryland 20659			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Charles Memorial Gardens 4/18/96		20c. LOCATION — City or Town, State Leonardtown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AMYOTROPHIC LATERAL SCLEROSIS							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. RESPIRATORY muscle weakness							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thimo</i>				29c. LICENSE NUMBER D34535		29d. DATE SIGNED (Month, Day, Year) 4.15.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 662 morning st # 101 Leonardtown MD 20650							
31. DATE FILED (Month, Day, Year) APR 18 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12006

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard Pearson</b>		2. Date of Death Month <b>April</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>9:08 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>		4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>219-56-1424</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr. 3, 1952</b>
	9. Birthplace (State or Foreign Country) <b>Wash. DC</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Prince Georges</b>	
	10c. City, Town or Location <b>Laurel</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>11717 S. Laurel Drive</b>		10f. Zip Code <b>20708</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sanitation Engineer</b>		16b. Kind of Business/Industry <b>F.D.A.</b>	
	17. Father's Name (First, Middle, Last) <b>Bernard Pearson, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Smith</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Fannie Pearson (Mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11717 S. Laurel Dr., Laurel, MD 20708</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. Nat'l Mem. Park</b>		20c. Location - City or Town, State <b>Laurel, MD</b>	
	21. Signature of Funeral Service Licensee <i>George R. Brunden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypertensive arteriosclerotic cardiovascular disease</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of):					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Adiposity</i>					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Augusto P. Rodriguez MD</i>		29c. License number <b>021230</b>		29d. Date signed (Month, Day, Year) <b>April 7, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cap. Spr. Md 20748</b>						
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature <i>John Stuchler</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



96 12007

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL R. POFFENBERGER</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>05</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>10:26 A</b> M	
4. SOCIAL SECURITY NUMBER <b>213-32-3519</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 28, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2400 Fairland Road</b>	
10f. ZIP CODE <b>20904</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Professor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>University</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George F. Poffenberger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Routzahn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gladys Poffenberger / Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2400 Fairland Road, Silver Spring, Maryland 20904</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>George Washington Cemetery 4/9/96</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Alan J. Donnell</b>				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Respiratory Failure</b> b. <b>Pneumonia</b> c. <b>Sepsis</b> Approximate Interval Between Onset and Death <b>Sudden</b> <b>2 wks</b> <b>2 wks</b> <b>2 wks</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>In situ carcinoma</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D-37332</b>		29d. DATE SIGNED (Month, Day, Year) <b>040596</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SK GUPTA 9801 Georgia Ave # 220 Silver Spring MD 20902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 09 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


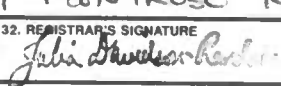
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12008

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEATRICE W. PEARCE</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>4</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>064-05-6803</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/18/1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6121 MONTROSE ROAD</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL WEINFELD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MOLLIE WASSERSTROM</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DR. MICHAEL PEARCE, SON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11125 KORMAN DRIVE, POTOMAC, MD 20854</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ETERNAL LIGHT CEMETERY 4/7/96</b>		20c. LOCATION — City or Town, State <b>BOYNTON BEACH, FL</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PARTIAL PROXIMAL SMALL BOWEL OBSTRUCTION</b>					Approximate Interval Between Onset and Death <b>1 DAY</b>
		b. <b>BOWEL ADHESIONS</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>P. Talwar, M.D.</b>				29c. LICENSE NUMBER <b>D 36552</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 4 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>P. TALWAR 6121 MONTROSE ROAD. ROCKVILLE MD. 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1996</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1541

96 12009

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Earl William Pierce</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 8 1996</b>		3. TIME OF DEATH <b>10:25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-4406</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 10, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1210 Old Mountain Road South</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Joppa</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Joppa</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1210 Old Mountain Road South</b>	
10f. ZIP CODE <b>21085</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineering Technician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Walter Howard Pierce</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ernestina Louise Kammer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Y. Pierce</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1210 Old Mountain Road South, Joppa, MD 21085</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Lutheran Cemetery 4/11/96 Joppa, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Mesothelioma - malignant</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ernest C. Bordon MD</i>				29c. LICENSE NUMBER <b>D13336</b>			
29d. DATE SIGNED (Month, Day, Year) <b>4/9/96</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Ernest Bordon, 22 South Greene St., Hematology/Oncology, Baltimore, MD 21201</b>			
31. DATE FILED (Month, Day, Year) <b>APR 10 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

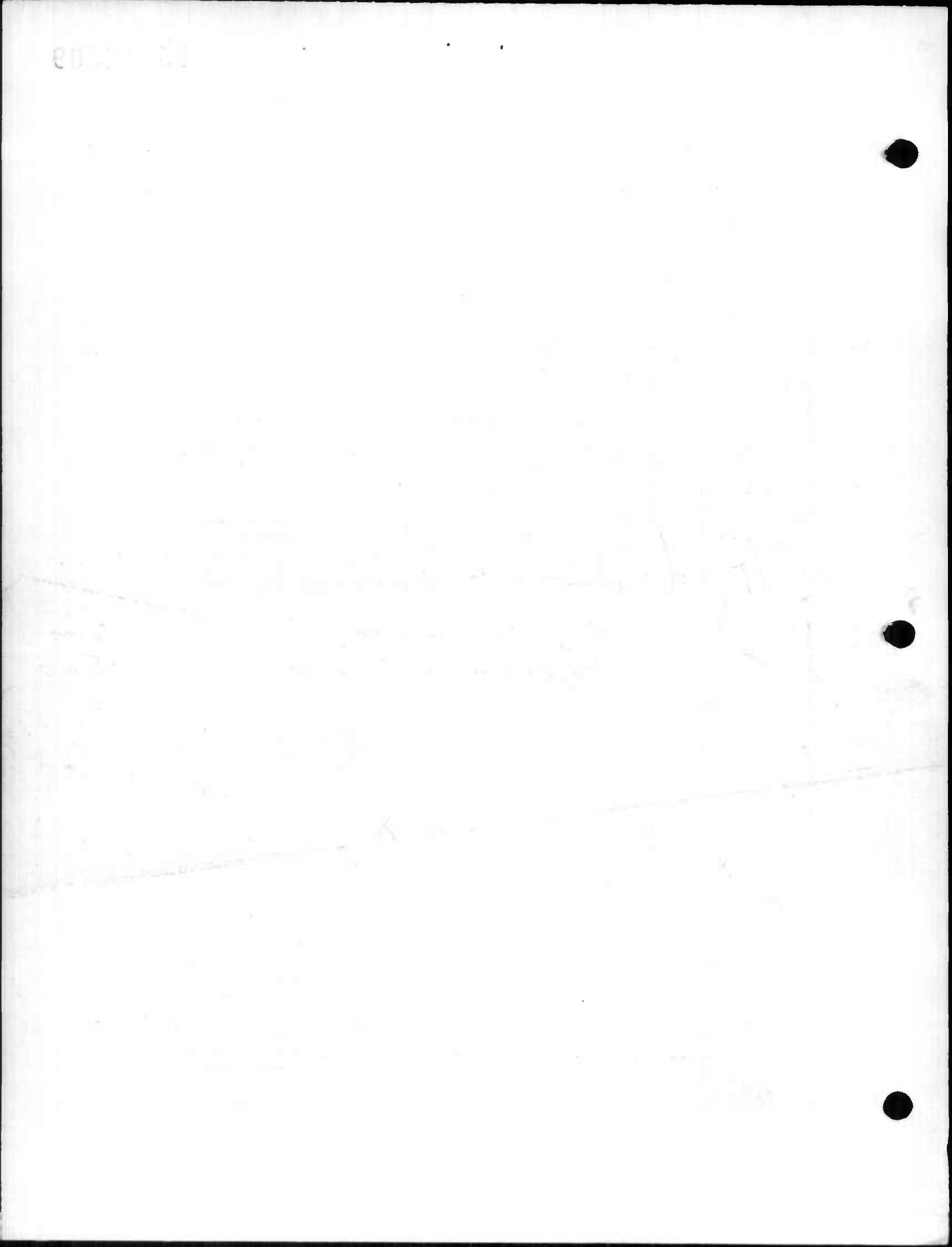
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


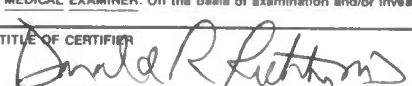





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>ALICE MARIE PROUDFOOT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 19, 1996</b>		3. TIME OF DEATH <b>7:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>233-46-9470</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC 13, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OAKLAND</b>		9c. COUNTY OF DEATH <b>GARRETT</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>GARRETT</b>		10c. CITY, TOWN OR LOCATION <b>OAKLAND</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>853 MONTE VISTA ROAD</b>				10f. ZIP CODE <b>21550</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MEDICAL TECHNICIAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HEALTH CARE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DWIGHT LAWTON ARNETT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NELLIE MARIE STRAWSER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT E. PROUDFOOT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 761 OAKLAND, MD 21550</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HUMAN GIFT REGISTRY</b>		DATE <b>4/19</b>		20c. LOCATION — City or Town, State <b>MORGANTOWN, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. terminal chronic obstructive pulmonary disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b> yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of hypertension</b> <b>History of seizure disorder</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D30035</b>		29d. DATE SIGNED (Month, Day, Year) <b>04-19-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald R. Richter MD 1533 Memorial Drive Oakland, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>APR 22 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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96 12011

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ZAIDEE MILLER QUAYLE</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>04</b> YEAR <b>96</b>		3. TIME OF DEATH <b>10:55 AM</b>	
4. SOCIAL SECURITY NUMBER <b>252-34-1858</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 31, 1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MISSOURI</b>				9a. FACILITY NAME (If not institution, give street and number) <b>WILLIAM HILL HEALTH CARE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>EASTON</b>	
9c. COUNTY OF DEATH <b>TALBOT</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>TALBOT</b>	
10c. CITY, TOWN OR LOCATION <b>EASTON</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>501 DUTCHMAN'S LANE</b>	
10f. ZIP CODE <b>21601</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE BROOKE MILLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ZAIDEE TENNENT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LOUISE O. KLING</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 STILLBROOK FARM LANE CENTREVILLE, MD 21617</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREM. CENTER 4-6</b>		20c. LOCATION — City or Town, State <b>CHESTER, MD. 21619</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. E. Newnam</i> CFSP				22. NAME AND ADDRESS OF FACILITY <b>FELLOWS, HELFENBEIN &amp; NEWNAM 200 S. HARRISON ST., EASTON, MD. 21601</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bowel obstruction, undetermined etiology</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>24 hrs.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>New onset atrial fibrillation</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. B. Sanchez</i> (physician)				29c. LICENSE NUMBER <b>225-752</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/4/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12012

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Rayfield Reed				2. Date of Death Month Day Year April 11, 1996		3. Time of Death 16:15	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Annes Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 217-07-0953		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Worton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11090 Old Worton Road		10f. Zip Code 21678		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Butcher/Meat Cutter		16b. Kind of Business/Industry Retail			
	17. Father's Name (First, Middle, Last) Howard Reed				18. Mother's Name (First, Middle, Maiden Surname) Ida Coleman Reed			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dorothy Reed/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11090 Old Worton Road, Worton, Maryland 21678			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery/April 14, 1996		20c. Location - City or Town, State Chestertown, Maryland		20d. Date April 14, 1996	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure Due to (or as a consequence of): End Stage Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year) none		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number S23889				29d. Date signed (Month, Day, Year) April 12, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John C. Arrabal, 948 Washington Avenue, Chestertown, Maryland 21620				31. Date filed (Month, Day, Year) APR 15 '96			
State Registrar	32. Registrar's Signature 				33. Date of Death APR 11, 1996			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marion Snyder Reed				2. Date of Death Month Day Year March 14, 1996		3. Time of Death 6:00 p.m.												
	4a. Facility Name (If not institution, give street and number) Heron Point				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent												
Funeral Director	5. Social Security Number 559-68-5369	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 2, 1910		9. Birthplace (State or Foreign Country) Rochester, New York											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No												
	10e. Street and Number 124 Heron Point				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic/Own Home												
	17. Father's Name (First, Middle, Last) Edward George Snyder				18. Mother's Name (First, Middle, Maiden Surname) Anna Nagel														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Walter Reed				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Bohemia Mill Road, Middletown, Delaware														
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory/March 14, 1996		Date Dover, Delaware		20c. Location - City or Town, State												
	21. Signature of Funeral Service Licensee <i>Gary B. Fellows</i>				22. Name and Address of Facility Fellows, Helfenbein, & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u></td> <td>Approximate Interval Between Onset and Death 10 yrs.</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>	Approximate Interval Between Onset and Death 10 yrs.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>	Approximate Interval Between Onset and Death 10 yrs.																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																		
	c. Due to (or as a consequence of):																		
	d. Due to (or as a consequence of):																		
	d. Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ATRIAL FIBRILLATION</u> <u>HYPERTENSION</u> <u>CEREBROVASCULAR DISEASE</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Helen A. Noble MD</i>		29c. License number D 41587		29d. Date signed (Month, Day, Year) March 15, 1996													
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Helen Noble, MD 122 Speer Road, Chestertown, Maryland 21620																			
31. Date filed (Month, Day, Year) MAR 15 '96		32. Registrar's Signature <i>Julia Davidson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 12014

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise Chasmar Rogers				2. DATE OF DEATH MONTH DAY YEAR April 14, 1996				3. TIME OF DEATH YEAR 8:40 P. M	
4. SOCIAL SECURITY NUMBER 217-44-5800		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 29, 1905		8. BIRTHPLACE (State or Foreign Country) Connecticut	
9a. FACILITY NAME (If not institution, give street and number) 228 Kingston Creek Road				9b. CITY, TOWN OR LOCATION OF DEATH California				9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland		10b. COUNTY St. Marys		10c. CITY, TOWN OR LOCATION California				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 228 Kingston Creek Road				10f. ZIP CODE 20619				10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) Greenleaf H. Chasmar				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Stivers					
19a. INFORMANT'S NAME (Type/Print) Nancy Rogers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Kingston Creek Road, California, Maryland 20619					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/15/96		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Carcinomatous</i> b. <i>Carcinoma of Ovary</i> c. d.  Approximate Interval Between Onset and Death <i>1 yr 9 mo</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <i>N/A</i>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe, M.D.</i>							
29c. LICENSE NUMBER D06419		29d. DATE SIGNED (Month, Day, Year) <i>4-15-96</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Patrick Jarboe, M.D. Medical Arts Bldg., Leonardtown, Maryland 20650									
31. DATE FILED (Month, Day, Year) <i>APR 18 1996</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12015

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Wilson

RAMSEY

2. Date of Death

Month Day Year  
MARCH 28 1996

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL AT EASTON

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

579-03-2280

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 28, 1916

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

P.O. Box 341

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

File Clerk

16b. Kind of Business/Industry

AARP

17. Father's Name (First, Middle, Last)

Thomas Adams

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Wilson

19a. Informant's Name/Relationship (Type, Print)

Charles E. Gilbert / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10143 Oakton Terrace Road, Oakton, Virginia 22124

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/1/96

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue

Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Pulmonary Embolism

24 HRS.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Urosepsis

24 HRS.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old CVA, Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wafik I. Zaki, M.D. 920 Market Street, Denton, Maryland 21629

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 09 1996

Julie Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12016**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN IRWIN RIESLAND

2. Date of Death

MARCH 30, 1996

3. Time of Death

1330 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10 RICE COURT

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

468-14-9565

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9, 1921

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Montgomery10c. City, Town or Location  
Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10 Rice Court

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: World  
War II13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nuclear Engineer

16b. Kind of Business/Industry

NRC

17. Father's Name (First, Middle, Last)

Frederick Riesland

18. Mother's Name (First, Middle, Maiden Surname)

Signe Peterson

19a. Informant's Name/Relationship (Type, Print)

Doris J. Riesland/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Rice Court, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Montgomery Crematorium, Inc.  
April 4, 1996

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Doris J. Riesland M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Carbon Monoxide Intoxication

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?

Partial

1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

3-30-96

28b. Time of  
Injury

Unknown AM

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Inhaled  
exhaust from Auto in Garage28e. Place of Injury - At home, term, street, factory, office  
building, etc. (Specify)

Residence

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

10 Rice Ct Rockville

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MARCH 31, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID R. FOWLER

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 08 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12017

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred McBain Regan				2. Date of Death Month Day Year April 3 1996		3. Time of Death 6:50 AM		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 217-28-8385		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 16, 1932	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Adelphi			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 10318 Aster Lane				10f. Zip Code 20783		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) George McBain				18. Mother's Name (First, Middle, Maiden Surname) Lucy Brown					
19a. Informant's Name/Relationship (Type, Print) Susan R. Winkler / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6002 Greenvale Parkway, Riverdale, Maryland 20737					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Data 4/8/96		20c. Location - City or Town, State Silver Spring, Maryland			
21. Signature of Funeral Service Licensee ▶ Alan J. Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ADULT RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): c. ACUTE LEUKEMIA Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 2 WKS 2 WKS 4 WKS									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COLLAGEN VASCULAR PLEURISY, RENAL INSUFFICIENCY									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ▶ Steven T. Kariya - MD		29c. License number D36252		29d. Date signed (Month, Day, Year) APR 4, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVEN T. KARIYA, MD, 11501 GEORGIA AVE STE 515 WILKATON MD 20902									
31. Date filed (Month, Day, Year) APR 09 1996		32. Registrar's Signature ▶ Julia Swisher-Rosell							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

VI





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12018

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SYLVIA RUBIN</b>		2. Date of Death Month <b>APRIL</b> Day <b>04</b> Year <b>1996</b>		3. Time of Death <b>2045</b>
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>186-01-5523</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Nov. 17, 1917</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5901 Montrose Road N800</b>		
	10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Merchant</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Merchant</b>		16b. Kind of Business/Industry <b>Gifts</b>		
	17. Father's Name (First, Middle, Last) <b>Louis Schwartz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Unknown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Kathy Bernstein</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Scotch Mist Court Potomac, Maryland</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Haym Solomon Memorial Park</b>		20c. Location - City or Town, State <b>Frazer, Pennsylvania</b>
	21. Signature of Funeral Service Licensee <b>John L. Chipchak</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>MULTIPLE PULMONARY EMBOLI</b> Due to (or as a consequence of): <b>HYPERCOAGULABILITY SYNDROME</b> Due to (or as a consequence of): <b>METASTATIC ADENOCARCINOMA OF THE LEFT LUNG</b>				Approximate Interval Between Onset and Death <b>4 DAYS</b> <b>3 1/2 MONTHS</b> <b>4 MONTHS</b> <b>4 1/2 MONTHS</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>				23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James G. Brown, MD</b>		29c. License number <b>D07285</b>
	29d. Date signed (Month, Day, Year) <b>APRIL 5, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES A. BROWN, MD 9707 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850</b>		
	31. Date filed (Month, Day, Year) <b>APR 10 1996</b>		32. Registrar's Signature <b>John Davidson-Roberts</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12019

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Mary Mildred Russell</b>				2. Date of Death Month <b>April</b> Day <b>9</b> Year <b>1996</b>		3. Time of Death <b>8:45 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>Carroll Lutheran Village</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>				
Funeral Director	5. Social Security Number <b>577-58-6147</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 17, 1902</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>			
	Usual Residence of Decedent				10e. Street and Number <b>200 St. Luke Circle</b>		10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>United States</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dept. Head</b>			16b. Kind of Business/Industry <b>Census Bureau</b>			
	17. Father's Name (First, Middle, Last) <b>Robert H. Mercer Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Eyler</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Grace Shaughney, niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>44 Pennsylvania Ave., Westminster, MD 21157</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>				
	21. Signature of Funeral Service Licensee <b>Katherine Pritts - Sweitzer</b>				22. Name and Address of Facility <b>Pritts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD 21157</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Cardiovascular Failure</u></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								Approximate Interval Between Onset and Death <b>Hours</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Denotes, High Blood Pressure</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D3302</b>		29d. Date signed (Month, Day, Year) <b>4/12/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen Siskowski, MD 912 Washington Rd</b>											
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>											
32. Registrar's Signature <b>[Signature]</b>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12020

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hazel William Robinson				2. Date of Death Month Day Year March 27, 1996				3. Time of Death 1:25 a.m.				
	4a. Facility Name (If not institution, give street and number) Magnolia Hall, Incorporated				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent				
Funeral Director	5. Social Security Number 218-05-8375		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) November 26, 1915		9. Birthplace (State or Foreign Country) Kennedyville, MD				
	10a. State Maryland				10b. County Kent		10c. City, Town or Location Kennedyville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 28044 Creamery Street				10f. Zip Code 21645				10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Collage (1-4 or 5+) Collage				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker				16b. Kind of Business/Industry Canning				
	17. Father's Name (First, Middle, Last) William J. Robinson				18. Mother's Name (First, Middle, Maiden Surname) Mary Etta Walmsley								
	19a. Informant's Name/Relationship (Type, Print) Merritt Robinson/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Blackhawk Lane, Garland, TX 75043								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kennedyville Cemetery/April 1, 1996 Kennedyville, MD		20c. Location - City or Town, State								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein, & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620								
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Pulmonary Embolus</u> Due to (or as a consequence of): c. <u>ASCD</u> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>To Bacco Abuse, H/O Attrial Fibrillation and Flutter, Malnourished and Cardiac</u> <u>Secondary to Poor Oral Intake</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) None		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 123889		29d. Date signed (Month, Day, Year) 3/28/96							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John C. Arrabal, MD, 948 Washington Avenue, Chestertown, Maryland 21620				31. Date filed (Month, Day, Year) MAR 29 '96				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



State  
Registrar



96 12021

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Milburn SUTTON				2. DATE OF DEATH MONTH March 23, DAY 1996 YEAR		3. TIME OF DEATH 6:45P M	
4. SOCIAL SECURITY NUMBER 213-22-8964		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 13, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Perry Point		9c. COUNTY OF DEATH Cecil	
9b. FACILITY NAME (If not institution, give street and number) VA Maryland Health Care System							
10a. STATE Maryland		10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Chestertown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 21254 Chesapeake Rd.				10f. ZIP CODE 21620		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber		16b. KIND OF BUSINESS/INDUSTRY Hair Care	
17. FATHER'S NAME (First, Middle, Last) Milburn Jackson Sutton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Louise Sutton			
19a. INFORMANT'S NAME (Type/Print) Ruth Helen Sutton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21254 Chesapeake Rd. Chestertown, MD. 21620			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Cremation 3/25		20c. LOCATION — City or Town, State Stevensville, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSE 				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein & Newnam Funeral Home P.A. Chestertown, Maryland			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Cerebral Vascular Accident							
DUE TO (OR AS A CONSEQUENCE OF):							
c.							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Manuel Ramos MD				29c. LICENSE NUMBER D38950		29d. DATE SIGNED (Month, Day, Year) 03/23/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Manuel Ramos, M.D., Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) MAR 26 '96		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12022

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BEVERLY

M.

SCHNAITMAN

2. Date of Death

Month  
APRILDay  
9Year  
1996

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL AT EASTON

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

327-20-1040

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

NOV. 12, 1925

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

WYE MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12520 WYE LANDING LANE

10f. Zip Code

21679

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ROLLO MARSHALL

18. Mother's Name (First, Middle, Maiden Surname)

LETTIE BROADSTREET

19a. Informant's Name/Relationship (Type, Print)

WILLIAM K. SCHNAITMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12520 WYE LANDING LANE, WYE MILLS, MD 21679

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHESAPEAKE CREMATORY 4-10

Data

20c. Location - City or Town, State

CHESTER, MD

21. Signature of Funeral Service Licensee

W. K. Schnaitman III C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Thomas Divilio

29c. License number

D24769

29d. Date signed (Month, Day, Year)

4/9/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. THOMAS DIVILIO, M.D., 404 MARVEL COURT, EASTON, MD 21601

31. Date filed (Month, Day, Year)

APR 11 1996

32. Registrar's Signature

Julia D. H. H. H.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen Augusta Stark</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>5</b> 96 YEAR <b>02-20-1894</b>		3. TIME OF DEATH <b>6:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>359-14-6644</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>102</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-20-1894</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Reeders Memorial Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Boonsboro, Maryland</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>204 E. Antietam Street</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Ruehlmann</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wilhelmine Boseck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen H. Ritner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>84 Essendon Way San Jose, Calif. 95139</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Irving Park Cemetery</b>		DATE <b>4/10</b>		20c. LOCATION — City or Town, State <b>Chicago, Illinois</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <b>Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ATHROSCLEROTIC CARDIAC DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1 1/2 HR</b> <b>Unknown</b> <b>20 YRS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SENILITY</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 6, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Zafar Malik, 20311 Iappans Road, Boonsboro, Maryland 21713</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



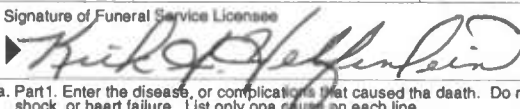
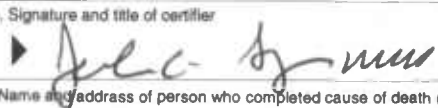
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12024

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Scull</b>				2. Date of Death Month <b>April</b> Day <b>6</b> Year <b>1996</b>				3. Time of Death <b>7:10 p.m.</b>					
	4a. Facility Name (If not institution, give street and number) <b>Corsica Hills Nursing Center</b>				4b. City, Town, or Location of Death <b>Centreville</b>				4c. County of Death <b>Queen Annes</b>					
Funeral Director	5. Social Security Number <b>221-01-6795</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>December 28, 1908</b>		9. Birthplace (State or Foreign Country) <b>Locust Grove, MD</b>	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>221 Richard Drive</b>				10f. Zip Code <b>21620</b>				10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Distribution Supervisor</b>				16b. Kind of Business/Industry <b>Parts Distributor</b>					
	17. Father's Name (First, Middle, Last) <b>Elisha Scull</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Powell</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Beatrice M. Scull/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>221 Richard Drive, Chestertown, Maryland 21620</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sudlersville Cemetery/April 10, 1996 Sudlersville, Maryland</b>				20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Artery Disease</b> Due to (or as a consequence of): <b>b. 1st Myocardial Infarction</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>												Approximate Interval Between Onset and Death <b>20 yrs</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D-13824</b>				29d. Date signed (Month, Day, Year) <b>4-10-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620</b>														
31. Date filed (Month, Day, Year) <b>APR 15 '96</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



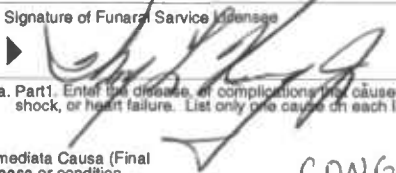
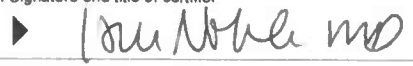
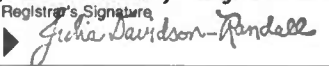
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12025

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susan Frances Stavelly</b>				2. Date of Death Month <b>March</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>5:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heron Point, 501 Campus Avenue</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>	
Funeral Director	5. Social Security Number <b>222-22-4735</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 31, 1901</b>	
	9. Birthplace (State or Foreign Country) <b>Fairlee, Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>2004 Heron Point</b>				10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Education</b>			
	17. Father's Name (First, Middle, Last) <b>Harry M. Stavelly</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Florence Bowers</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Joseph Rennie Stavelly (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2206 Apple Tree Lane, Silver Spring, Maryland 20905</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>I.U. Cemetery</b>		20c. Location - City or Town, State <b>March 5, 1996 Worton, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fellows, Helfenbein, &amp; Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>			
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  b. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 yrs.</b> <b>20 yrs.</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D41587</b>		29d. Date signed (Month, Day, Year) <b>March 7, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen Noble, MD, Speer Road, Chestertown, Maryland 21620</b>								
31. Date filed (Month, Day, Year) <b>MAR 07 '96</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 12026

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gaetana Stefano (Gaetana Stefano)				2. DATE OF DEATH MONTH DAY YEAR March 10, 1996		3. TIME OF DEATH 1530 P M	
4. SOCIAL SECURITY NUMBER 158-26-7766		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 5, 1902	
8. BIRTHPLACE (State or Foreign Country) Sicily, Italy				9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Co. Hospital Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Chestertown	
9c. COUNTY OF DEATH Kent				10a. STATE Maryland		10b. COUNTY Kent	
10c. CITY, TOWN OR LOCATION Chestertown				10d. INSIDE CITY LIMITS? XX YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 844 High Street	
10f. ZIP CODE 21620				10g. CITIZEN OF WHAT COUNTRY? Italy		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Italian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Domestic/Own Home	
17. FATHER'S NAME (First, Middle, Last) Barbera Giuseppe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Furnari Concetta			
19a. INFORMANT'S NAME (Type/Print) Enza Lombardo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 High Street, Chestertown, Maryland 21620			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Cemetery/March 15, 1996		20c. LOCATION — City or Town, State Easton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay B. Fellows</i>				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. C. Seymour</i>				29c. LICENSE NUMBER D-13824		29d. DATE SIGNED (Month, Day, Year) 3-11-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Seymour, MD, 122 Speer Road, Chestertown, Maryland 21620							
31. DATE FILED (Month, Day, Year) MAR 14 '96				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



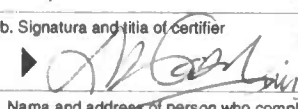
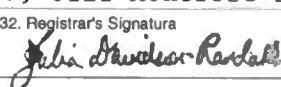
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12027

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>Indira Sen</b>		2. Date of Death Month <b>April</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>1:35 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Potomac</b>		4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>213-08-4729</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 7, 1917</b>		9. Birthplace (State or Foreign Country) <b>India</b>		
To Be Completed by Funeral Director	Usual Residence of Decedant		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>
	10c. City, Town or Location <b>Potomac</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>8502 Timber Hill Lane</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>India</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+) <b>2</b>		
	16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Hemchandra Sen</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Labanya Probha Devi</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Subir K. Sen/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8502 Timber Hill Lane, Potomac, Maryland 20854</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>
	21. Signature of Funeral Service Licensee  <b>M00846</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>		
23a. Partly Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immadiata Causa (Final disease or condition resulting in death)  a. <b>Chronic Cor Pulmonale</b> Dua to (or as a consequence of): b. <b>Chronic Asthmatic Bronchitis</b> Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death <b>10 Years</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Chronic Atrial Fibrillation</b> <b>Right Cerebral Infarct, Old</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <b>April 6, 1996</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how Injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  <b>Attending Physician</b>					
29c. License number <b>D18084</b>					
29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>					
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dineshbhai Patel, M.D., 6121 Montrose Road, Rockville, Maryland 20852-4856</b>					
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12028

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Hollis Stewart				2. DATE OF DEATH MONTH DAY YEAR April 7 1996		3. TIME OF DEATH 9:25 P M	
4. SOCIAL SECURITY NUMBER 577-38-5635		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 8, 1911	
8. BIRTHPLACE (State or Foreign Country) Douds, Iowa				9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 415 Russell Avenue #316	
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant/Lawyer		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) George Stewart				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Countryman			
19a. INFORMANT'S NAME (Type/Print) L. Blanche Stewart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue #316, Gaithersburg, MD 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 4/9/96		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Carberry</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ventricular arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <u>sudden</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>cardiovascular disease</u> <u>dementia</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. Melnick</i>				29c. LICENSE NUMBER D19294		29d. DATE SIGNED (Month, Day, Year) April 7, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John R. Melnick 511 Russell Ave Gaithersburg Md 20877</i>							
31. DATE FILED (Month, Day, Year) APR 09 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson Rusk</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12029

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Spicer				2. Date of Death Month April 3, Day 1996 Year				3. Time of Death 10:50 AM					
	4a. Facility Name (If not institution, give street and number) Montgomery General				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 578-09-0931		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sep. 4, 1909		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 3107 Adderley Court				10f. Zip Code 20906				10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant				16b. Kind of Business/Industry University					
	17. Father's Name (First, Middle, Last) Fred Spicer				18. Mother's Name (First, Middle, Maiden Surname) Mae J. Jasper									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Virginia Boothe Spicer / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Adderley Court, Silver Spring, Maryland 20906									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery				Date 4/8/96		20c. Location - City or Town, State Suitland, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Respiratory Arrest Due to (or as a consequence of): b. Malnutrition Due to (or as a consequence of): c. Colon Cancer Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 min. 3 weeks 6 mos.													
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)														
28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 				29c. License number D24190				29d. Date signed (Month, Day, Year) 4-4-96						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #205 3416 OLANWOOD CT OLNEY MD 20832 ARTHUR WOODWARD														
31. Date filed (Month, Day, Year) APR 09 1996				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12030

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aloysius A. Skrypzak

2. Date of Death

April 7, 1996

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

Brooke Grove Nursing &amp; Rehabilitation

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

190-20-4737

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 22, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14804 Notley Road

10f. Zip Code

20905

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Supervisor of Rehabilitation

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Francis Skrzypzak

18. Mother's Name (First, Middle, Maiden Surname)

Anna Nagorski

19a. Informant's Name/Relationship (Type, Print)

Norma S. Skrypzak

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14804 Notley Road Silver Spring, Maryland 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 4/11/96 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Timothy D. Campbell

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 20901  
500 University Blvd., W. Silver Spring, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

NANITION  
ABDOMINAL CARCINOMATOSIS

Approximate Interval Between Onset and Death

TERM.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

ADENOCARCINOMA STOMACH

15 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald R. Lewis MD

29c. License number

D06406

29d. Date signed (Month, Day, Year)

APRIL 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD RT108 OLNEY, MD 20832

31. Date filed (Month, Day, Year)

APR 10 1996

32. Registrar's Signature

John Davidson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12031

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Danna Fay Swanson</i>				2. Date of Death Month <i>April</i> Day <i>08</i> Year <i>1996</i>		3. Time of Death <i>1055 Am</i>	
	4a. Facility Name (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>				4b. City, Town, or Location of Death <i>Rockville</i>		4c. County of Death <i>Montgomery</i>	
<b>Funeral Director</b>	5. Social Security Number <i>233-64-3209</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 16, 1939</i>	
	9. Birthplace (State or Foreign Country) <i>West Virginia</i>		10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Germantown</i>	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>18623 Glen Willow Way</i>		10f. Zip Code <i>20874</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Mortgage Insurance Processor</i>		16b. Kind of Business/Industry <i>Banking</i>			
	17. Father's Name (First, Middle, Last) <i>John Hobert Carpenter</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Allie Fair Mullins</i>		19a. Informant's Name/Relationship (Type, Print) <i>Claude A. Swanson</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>18623 Glen Willow Way, Germantown, Maryland 20874</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery</i>		Date <i>4/11/96</i>		20c. Location - City or Town, State <i>Silver Spring, MD</i>	
	21. Signature of Funeral Service Licensee <i>Matthew Pikel</i>		22. Name and Address of Facility <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West, Silver Spring, MD 20901</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>pneumonia</i> Due to (or as a consequence of):		b. <i>bronchogenic non-small cell carcinoma</i> Due to (or as a consequence of):		c. Due to (or as a consequence of):	
			d. Due to (or as a consequence of):				Approximate interval between Onset and Death <i>4 days</i> <i>22 months</i>	
<b>Physician /Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>George A. Sotos M.D.</i>		29c. License number <i>D43083</i>		29d. Date signed (Month, Day, Year) <i>April 08, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>George A. Sotos M.D. 9707 Medical Center Drive #300 Rockville, MD 20850</i>								
31. Date filed (Month, Day, Year) <i>APR 11 1996</i>		32. Registrar's Signature <i>Julia Swanson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Joseph M. Streett, Jr.</u>			2. DATE OF DEATH MONTH <u>April</u> DAY <u>05</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>2:50 A</u> M	
4. SOCIAL SECURITY NUMBER <u>217-16-7451</u>	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>80</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>4/30/1915</u>	8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>		
9a. FACILITY NAME (If not institution, give street and number) <u>Fallston General Hospital</u>			9b. CITY, TOWN OR LOCATION OF DEATH <u>Fallston</u>		9c. COUNTY OF DEATH <u>Harford</u>	
RESIDENCE OF DECEDENT						
10a. STATE <u>Maryland</u>	10b. COUNTY <u>Harford</u>	10c. CITY, TOWN OR LOCATION <u>Street</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <u>1015 Federal Hill Road</u>		10f. ZIP CODE <u>21154</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
14. RACE — American Indian, Black, White, etc. <u>White</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>				
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Carpenter</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Construction</u>				
17. FATHER'S NAME (First, Middle, Last) <u>Joseph M. Streett, Sr.</u>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elizabeth Nelson</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Phyllis Jean Streett</u>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1015 Federal Hill Road Street, MD 21154</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Holy Cross Cemetery 4/8</u>		20c. LOCATION — City or Town, State <u>Street, MD</u>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Jeffrey P. Lovelidge</u>			22. NAME AND ADDRESS OF FACILITY <u>Harkins Funeral Home, Inc. Delta, PA</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. atherosclerotic coronary vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>adenocarcinoma of Rectum</u>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <u>M</u>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Francis J. Veloz M.D.</u>			29c. LICENSE NUMBER <u>D34237</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/5/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <u>9515 Harford Rd. Francis J. Veloz M.D.</u>						
31. DATE FILED (Month, Day, Year) <u>4/5/96</u>		32. REGISTRAR'S SIGNATURE <u>Johanna Davidson-Randall</u>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12033

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Mary V. SHIELDS				2. DATE OF DEATH MONTH DAY YEAR April 14, 1996		3. TIME OF DEATH 11:15 P.M.	
4. SOCIAL SECURITY NUMBER 234-60-4392		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1906	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Dennett Road Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
10a. STATE WV		10b. COUNTY Preston		10c. CITY, TOWN OR LOCATION Rowlesburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 281				10f. ZIP CODE 26425		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 8th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Charles ----- Wilhelm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace ----- Hartsell			
19a. INFORMANT'S NAME (Type/Print) Donald Shields				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 311, Rowlesburg, WV 26425			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Watkins Cemetery		DATE 4/17		20c. LOCATION — City or Town, State Rowlesburg, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 Hour Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D33464		29d. DATE SIGNED (Month, Day, Year) April 15, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Coughlin, M.D. P.O. Box 8, Eglon, WV 26716							
31. DATE FILED (Month, Day, Year) APR 17 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12034

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD GERALD SADLER</b>				2. Date of Death Month <b>APRIL</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>11:50 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-24-6604</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>5-14-1928</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Manchester</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>3607 Rockdale Rd.</b>				10f. Zip Code <b>21102</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Hecht's Dept.</b>			
	17. Father's Name (First, Middle, Last) <b>Edward G. Sadler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Crowfoot</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Florence Sadler</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3607 Rockdale Rd. Manchester, MD 21102</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation</b>		Data <b>4/12</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>	
	21. Signature of Funeral Service Licensee <b>Kerri M. Reider</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St. Hampstead, Md 21074</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>a. Intracerebral bleeding</b> Due to (or as a consequence of):</p> <p><b>b. Metastatic brain cancer</b> Due to (or as a consequence of):</p> <p><b>c. Lung Cancer</b> Due to (or as a consequence of):</p> <p><b>d.</b></p> </div> <div style="width: 25%;"> <p>Approximate Interval Between Onset and Death <b>48 hours</b> <b>months</b> <b>years</b></p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown								
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No				
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Evangelos C. Lignos MD</b>				29c. License number <b>D19589</b>		29d. Date signed (Month, Day, Year) <b>4-11-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>EVANGELOS C. LIGNOS MD 7801 YORK RD TOWSON 21204</b>								
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature <b>J. A. Anderson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12035

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWIN ALLEN TORBERT</b>				2. Date of Death Month Day Year <b>April 7 1996</b>		3. Time of Death <b>8:25p</b>		
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital @ Easton</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>		
Funeral Director	5. Social Security Number <b>220-12-0718</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 8, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>CAROLINE</b>		10c. City, Town or Location <b>DENTON</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>EIGHTH ST., APT. 504</b>		10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FARMER</b>		16b. Kind of Business/Industry <b>POULTRY FARMING</b>					
17. Father's Name (First, Middle, Last) <b>LAWRANCE J. TORBERT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BLANCHE BUTLER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>WILLIAM J. TORBERT</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27325 GREENWOOD ROAD, DENTON, MD 21629</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>UPPER BAMBURY CEMETERY 4-10</b>		20c. Location - City or Town, State <b>TRAPPE, MD</b>					
21. Signature of Funeral Service Licensee <b>M. E. Newnam CFSP</b>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Transitional Cell Carcinoma Bladder 5y</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Carla Haller MD</b>		29c. License number <b>D35284</b>		29d. Date signed (Month, Day, Year) <b>4/8/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREA ALLEN MD PO Box 496 Denton MD 21629</b>									
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>		32. Registrar's Signature <b>J. A. Anderson-Rodall</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Cecil Glenwood Taylor				2. DATE OF DEATH MONTH DAY YEAR April 11, 1996				3. TIME OF DEATH 2030P M			
4. SOCIAL SECURITY NUMBER 213-10-8589		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 18, 1910		8. BIRTHPLACE (State or Foreign Country) Rock Hall, Maryland			
9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Co Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Chestertown				9c. COUNTY OF DEATH Kent			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Rock Hall				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5910 Rock Hall Road				10f. ZIP CODE 21661				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Line Worker				16b. KIND OF BUSINESS/INDUSTRY Food Manufacturer			
17. FATHER'S NAME (First, Middle, Last) James Thomas Taylor						18. MOTHER'S NAME (First, Middle, Maiden Surname) Olivia Webb					
19a. INFORMANT'S NAME (Type/Print) Marie Dowling Taylor/Wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5910 Rock Hall Road, Rock Hall, Maryland 21661							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wesley Cemetery/April 14, 1996				20c. LOCATION — City or Town, State Rock Hall, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. unstable angina DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER m. Bienenfeld				29c. LICENSE NUMBER 033514				29d. DATE SIGNED (Month, Day, Year) 4-12-96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael Bienenfeld, 100 Brown Street, Chestertown, Maryland 21620											
31. DATE FILED (Month, Day, Year) APR 15 '96				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12037

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Virginia Tapp				2. DATE OF DEATH MONTH DAY YEAR March 7, 1996		3. TIME OF DEATH 8:10 A	
4. SOCIAL SECURITY NUMBER 182-18-2743		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Chestertown	
9c. COUNTY OF DEATH Kent				10a. STATE Maryland		10b. COUNTY Kent	
10c. CITY, TOWN OR LOCATION Millington				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 32830 Cypress Road	
10f. ZIP CODE 21651				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Processor		16b. KIND OF BUSINESS/INDUSTRY Food Industry	
17. FATHER'S NAME (First, Middle, Last) Clarence Ricketts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Brown			
19a. INFORMANT'S NAME (Type/Print) Marqurite Dickerson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32830 Cypress Road, Millington, Maryland 21651			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cemetery - March 16, 1996		20c. LOCATION — City or Town, State Millington, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr.				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein, & Newnam Funeral Home 370 Cypress Street, Millington, Maryland 21651			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD							
e. DUE TO (OR AS A CONSEQUENCE OF):							
HOW							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obesity/contribution of ABD PAIN TO Develop UNCERTAIN							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year) N/A							
28b. TIME OF INJURY M							
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED N/A							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Sally J. Clum							
29c. LICENSE NUMBER D36054							
29d. DATE SIGNED (Month, Day, Year) 3/7/96							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patrick G. SARNOWSKI MD. 120 SPRIER RD CHESTERTOWN MD 21613							
31. DATE FILED (Month, Day, Year) 3/7/96 MAR 13 '96							
32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12038

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret L. Thompson</b>						2. Date of Death Month <b>04</b> Day <b>09</b> Year <b>1996</b>		3. Time of Death <b>8:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Hillhaven Nursing Home</b>						4b. City, Town, or Location of Death <b>Adelphi</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>218-38-8575</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 2, 1907</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Lanham</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>9405 Presley Place</b>				10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cafeteria Worker</b>			16b. Kind of Business/Industry <b>Montgomery County School</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Moeller</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lou Ott</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Cara Boyce</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9405 Presley Place, Lanham, Maryland 20706</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Gardens</b>			Data <b>4/12/96</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Avenue</b> <b>Silver Spring, Maryland 20904</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>STROKE</b> Dua to (or as a consequence of): <b>ATHEROSCLEROSIS</b> Dua to (or as a consequence of):  <b>DEMENTIA</b> <b>HYPOTHYROIDISM</b>								Approximate Interval Between Onset and Death <b>2 WEEKS</b> <b>MANY YEARS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier <b>Charles M. Benner MD</b>						29c. License number <b>D31563</b>		29d. Date signed (Month, Day, Year) <b>APRIL 9, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES M. BENNER, MD 11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20901</b>									
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>						32. Registrar's Signature <i>[Signature]</i>				



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ila L. Trantham</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 7 1996</b>		3. TIME OF DEATH <b>11:00A M</b>																										
4. SOCIAL SECURITY NUMBER <b>239-26-7031</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 11, 1918</b>																										
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. COUNTY OF DEATH <b>Montgomery</b>																												
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>																										
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Potomac</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO																										
10e. STREET AND NUMBER <b>10820 Hob Nail Court</b>				10f. ZIP CODE <b>20854</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>																										
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>																										
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Public Schools</b>																												
17. FATHER'S NAME (First, Middle, Last) <b>George W. Ledbetter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Nesbitt</b>																												
19a. INFORMANT'S NAME (Type/Print) <b>Hillary V. Trantham</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10820 Hob Nail Court, Potomac, Maryland 20854</b>																												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. LOCATION — City or Town, State <b>Rockville, Maryland</b>		20d. DATE <b>April 9, 1996</b>																										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Anderson</i> <b>M00284</b>				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>																												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																																
<table border="0"> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</td> <td>a.</td> <td>Bowel perforation</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>5 days</td> </tr> <tr> <td>b.</td> <td>Ischemic bowel disease</td> <td>7 days</td> </tr> <tr> <td></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> <tr> <td></td> <td>c.</td> <td>Arteriosclerosis</td> <td>15 years</td> </tr> <tr> <td></td> <td></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> <tr> <td></td> <td>d.</td> <td>Hypertension</td> <td>20 years</td> </tr> </table>								Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a.	Bowel perforation	Approximate Interval Between Onset and Death		DUE TO (OR AS A CONSEQUENCE OF):	5 days	b.	Ischemic bowel disease	7 days		DUE TO (OR AS A CONSEQUENCE OF):			c.	Arteriosclerosis	15 years			DUE TO (OR AS A CONSEQUENCE OF):			d.	Hypertension	20 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a.	Bowel perforation	Approximate Interval Between Onset and Death																													
		DUE TO (OR AS A CONSEQUENCE OF):	5 days																													
	b.	Ischemic bowel disease	7 days																													
		DUE TO (OR AS A CONSEQUENCE OF):																														
	c.	Arteriosclerosis	15 years																													
		DUE TO (OR AS A CONSEQUENCE OF):																														
	d.	Hypertension	20 years																													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																
<b>Breast cancer metastatic to bones</b> <b>Alzheimers dementia</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>																																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																														
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO																										
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)																												
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																																
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carol W. Garvey M.D.</i>				29c. LICENSE NUMBER <b>D13595</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1996</b>																										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carol W. Garvey, M.D. 250 Hungerford Drive, Rockville, Maryland 20850</b>																																
31. DATE FILED (Month, Day, Year) <b>APR 11 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>																												

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12040

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ruby Tindal</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 5 1996</b>		3. TIME OF DEATH <b>9:25 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>579-16-8203</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 13, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Fairland Adventist Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>600 Great Falls Road</b>				10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>7th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesperson</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Avon Products</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Percival J. Jonemond</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Copeland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nina Clarke (Niece)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>600 Great Falls Rd., Rockville, MD 20850</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Jerusalem Church Cem. 4/10</b>		20c. LOCATION — City or Town, State <b>Poolesville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>CardioPulmonary Arrest</b>				Approximate Interval Between Onset and Death <b>Sudden</b>	
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF): <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebro Vascular Accident</b>				<b>Days</b> <b>Week</b> <b>Months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-3232</b>		29d. DATE SIGNED (Month, Day, Year) <b>04 09 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9801 Georgia Ave # 220 Silver Spring Md 20902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12041

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony TRENT

2. Date of Death

April 6, 1996

3. Time of Death

12:20 A.M.

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

558-42-9937

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 1, 1934

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Mississippi

10b. County

Oktibeha

10c. City, Town or Location

Starkville

10d. Inside City Limits

1XXes 2□No

10e. Street and Number

1377 Sykes Road

10f. Zip Code

39759

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married XX Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XXYes 2□No

If Yes, Give Year or Dates:

1956-

1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes XXNo Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+ 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computers

16b. Kind of Business/Industry

United States Marines

17. Father's Name (First, Middle, Last)

John Anthony Trent

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Koeder

19a. Informant's Name/Relationship (Type, Print)

Kay Trent (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1□ Burial XX Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

4/7/1996

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Md. 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. renal insufficiency  
Due to (or as a consequence of):

7 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Waldenström's macroglobulinemia  
Due to (or as a consequence of):

24 mos

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

- coagulopathy  
- hepatic encephalopathy  
- anemia

23b. Did tobacco use contribute to the cause of death?

1□ Yes XXNo 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes XXNo

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes XXNo

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

26. Place of Death (Check only one)

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1□ Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1□ Yes XXNo

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□ Certifying Physician

2□ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marian O. Wietzen

29c. License number

D23743

29d. Date signed (Month, Day, Year)

APR 6 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARTIN WELTZ 7525 GREENWAY CIR IN GREENBELT, MARYLAND 20770

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

Julia Davidson-Rosell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12042

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Esther Suzanne Tawil</b>				2. Date of Death Month <b>April</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>6:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>11816 Milbern Drive</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>217-92-4119</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 19, 1924</b>	
9. Birthplace (State or Foreign Country) <b>Egypt</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11816 Milbern Drive</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		18b. Kind of Business/Industry <b>Own Home</b>		16. Decedent's Usual Residence (Specify only highest grade completed)	
17. Father's Name (First, Middle, Last) <b>Albert Mizrahi</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Suzanne Castel</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gaston S. Tawil</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>4-6-96 Beltsville, Maryland</b>		21. Signature of Funeral Service Licensee <b>Eden H. Rapp</b>	
22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Colorectal Cancer</b> Due to (or as a consequence of): <b>Sepsis</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Claudine Isaacs</b>	
29c. License number <b>20270</b>		29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Claudine Isaacs, M. D. for John L. Marshall, M. D., 3800 Reservoir Road, NW, Washington, DC 20007</b>		31. Date filed (Month, Day, Year) <b>APR 08 1996</b>	
32. Registrar's Signature <b>John Davidson Rapp</b>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Colorectal Cancer</b> Due to (or as a consequence of): <b>Sepsis</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>Claudine Isaacs</b>		29c. License number <b>20270</b>	
29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Claudine Isaacs, M. D. for John L. Marshall, M. D., 3800 Reservoir Road, NW, Washington, DC 20007</b>	
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>		32. Registrar's Signature <b>John Davidson Rapp</b>	
33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	
35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.		36. Medical Certification: To Be Completed by Physician/Medical Examiner	

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 12043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DONALD LOUIS TODARO</b>				2. Date of Death Month <b>APRIL</b> Day <b>9</b> Year <b>1996</b>		3. Time of Death <b>1228 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>208-26-6718</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 6, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Edgewood</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>1922 Harewood Rd.</b>				10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Guidance Counselor</b>		16b. Kind of Business/Industry <b>Education</b>			
	17. Father's Name (First, Middle, Last) <b>Louis George Todaro</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Clementine Schopp</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Eleanor K. Todaro - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1922 Harewood Rd., Edgewood, Md. 21040</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		20c. Location - City or Town, State <b>4-13-96 Bel Air, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Stephen A. Hughes</i>				22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>CORONARY ARTERY DISEASE</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>ATHEROSCLEROSIS</b></p> <p>Due to (or as a consequence of):</p> <p>c. </p> <p>Due to (or as a consequence of):</p> <p>d. </p> </div> <div> <p>Approximate Interval Between Onset and Death <b>5-10 min</b></p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>NONE</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Archana Sood MD</i>								
29c. License number <b>D41080</b>								
29d. Date signed (Month, Day, Year) <b>4-10-96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ARCHANA SOOD, 626 TOWN CENTRE DR. TOPPA Md. 21085</b>								
31. Date filed (Month, Day, Year) <b>APR 10 1996</b>								
32. Registrar's Signature <i>John A. Randall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

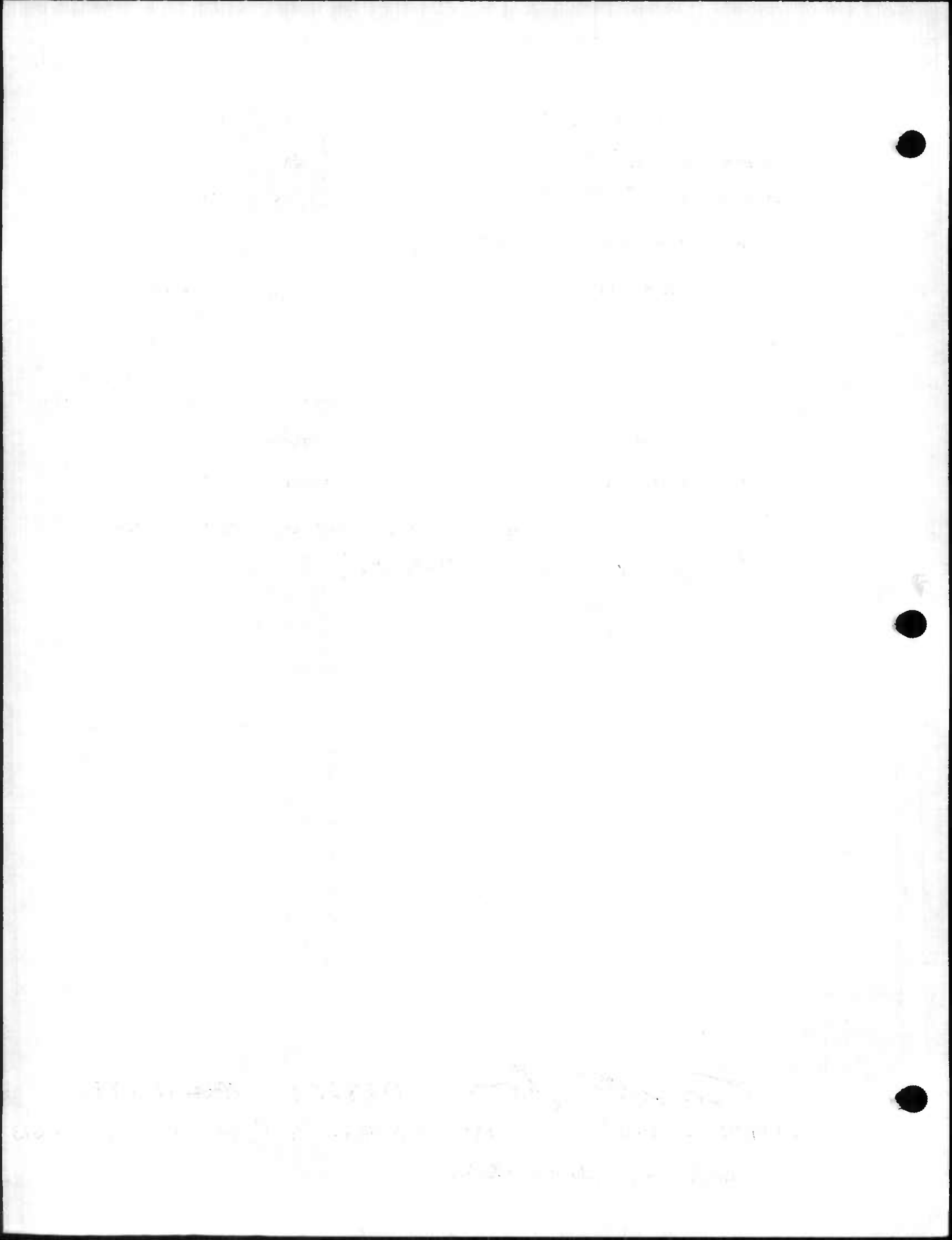
96 12044

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div align="center">MARIE M. TALL</div>				2. Date of Death Month Day Year April 11 1996		3. Time of Death 0440	
	4a. Facility Name (If not institution, give street and number) Mallard Bay Nursing Center				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester	
<b>Funeral Director</b>	5. Social Security Number 214-07-7235		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) May 26 1914	
	10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number 409 Atlantic Ave.				10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sewing machine operator		16b. Kind of Business/Industry garment manufacturing	
	17. Father's Name (First, Middle, Last) Edward Elzey				18. Mother's Name (First, Middle, Maiden Surname) Maggie Smith			
	19a. Informant's Name/Relationship (Type, Print) Mace E. Tall Jr. / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Talbot Ave., Cambridge, MD 21613			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		20c. Location - City or Town, State 4/14 Cambridge Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home 700 Locust St. Cambridge, MD 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"><div style="width: 60%;">Immediate Cause (Final disease or condition resulting in death) <div align="center"><u>Parkinson's Disease</u></div> Due to (or as a consequence of): <div style="display: flex; align-items: center;"><div style="font-size: 3em; margin-right: 10px;">{</div><div style="margin-left: 10px;">b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____</div></div></div><div style="width: 35%; text-align: center;">Approximate Interval Between Onset and Death <u>2 years</u></div></div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D28209		29d. Date signed (Month, Day, Year) APR 11, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDMUND J. MACLAUGHLIN, MD 4 AURORA ST, CAMBRIDGE, MD 21613								
31. Date filed (Month, Day, Year) APR 12 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 12045

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAULINE HELEN VOJTEK

2. Date of Death

MARCH

Day Year  
9th. 1996

3. Time of Death

2pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CORSICA HILLS NURSING HOME

4b. City, Town, or Location of Death

CENTREVILLE

4c. County of Death

QUEEN ANNES

5. Social Security Number

047-26-2015

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 3, 1909

9. Birthplace (State or Foreign Country)

Czechoslovakia

Usual Residence of Decedent

10a. State

Maryland

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

206 Mt. VERNON AVE.

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

NICHOLAS KUNAK

18. Mother's Name (First, Middle, Maiden Surname)

MARY KUNAK

(SAME FAMILY)

19a. Informant's Name/Relationship (Type, Print)

MARGARET HELEN SLAMA, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 Mt. Vernon Ave. Chestertown, Md. 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Johns Cemetery

Date

3/13/96

20c. Location - City or Town, State

STRATFORD, CONN.

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME

130 SPEER RD. CHESTERTOWN, MD. 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY DISTRESS

2 Years

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. RECENT HYPEROSMOLAR COMA

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35048

29d. Date signed (Month, Day, Year)

3/10/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC F. CIGANEK, 109 S. COMMERCE ST. CENTREVILLE, MD. 21617

31. Date filed (Month, Day, Year)

MAR 13 '96

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12046

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Marcel Valette</b>		2. Date of Death Month <b>April</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>2:05 PM</b>																						
4a. Facility Name (If not institution, give street and number) <b>3903 Byrd Road</b>		4b. City, Town, or Location of Death <b>Kensington</b>		4c. County of Death <b>Montgomery</b>																						
5. Social Security Number <b>214-39-8607</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.																						
8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1911</b>		9. Birthplace (State or Foreign Country) <b>France</b>																								
Usual Residence of Decedent																										
10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>																						
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3903 Byrd Road</b>		10f. Zip Code <b>20895</b>																						
10g. Citizen of What Country? <b>France</b>		11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:																						
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)																						
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Policeman</b>		16b. Kind of Business/Industry <b>French Government</b>		17. Father's Name (First, Middle, Last) <b>Jean Baptiste Valette</b>																						
18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Marianne Tana</b>		19a. Informant's Name/Relationship (Type, Print) <b>Nathalie Valette Silver</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>																						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>4-5-96 Beltsville, Maryland</b>																						
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
<table border="0"> <tr> <td rowspan="4">           Immediata Causa (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Respiratory Failure</b></td> <td>months</td> </tr> <tr> <td colspan="3">Dua to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Chronic Obstructive Lung Disease</b></td> <td>years</td> </tr> <tr> <td colspan="3">Dua to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Dua to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3">Dua to (or as a consequence of):</td> </tr> </table>						Immediata Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Respiratory Failure</b>	months	Dua to (or as a consequence of):			b.	<b>Chronic Obstructive Lung Disease</b>	years	Dua to (or as a consequence of):			c.	Dua to (or as a consequence of):			d.	Dua to (or as a consequence of):		
Immediata Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Respiratory Failure</b>	months																							
	Dua to (or as a consequence of):																									
	b.	<b>Chronic Obstructive Lung Disease</b>	years																							
	Dua to (or as a consequence of):																									
c.	Dua to (or as a consequence of):																									
d.	Dua to (or as a consequence of):																									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.																										
<b>Arteriosclerotic Cardiovascular Disease</b>																										
<b>Carcinoma of Prostate</b>																										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>																						
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																										
29b. Signature and title of certifier 		29c. License number <b>D07792</b>		29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>																						
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Ernest S. Oser, M. D., 10301 Georgia Avenue, #304, Silver Spring, MD 20902</b>																										
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>		32. Registrar's Signature 																								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



96 12047

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen Dorthy Vissing</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 8, 1996</b>		3. TIME OF DEATH <b>8:45 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>381-18-9407</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 7, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Michigan</b>				9a. FACILITY NAME (If not institution, give street and number) <b>16616 Killdeer Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10. RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>16616 Killdeer Drive</b>				10f. ZIP CODE <b>20855</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Foreign Affairs Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clarence J. Huntley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine VanCort</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Guy S. Vissing</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16616 Killdeer Drive, Rockville, MD 20855</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Hope Cemetery 4/13/96</b>		20c. LOCATION — City or Town, State <b>Lynchfield, Michigan</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gilman</i>				22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma Of The Right Breast</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>18Months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Brown MD</i>				29c. LICENSE NUMBER <b>D 07285</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Brown, 9707 Medical Center Drive, #300, Rockville, Maryland 20850</b>							
31. DATE FILED (Month, Day, Year) <b>APR 09 1996</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Roberts</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

96 12048

UNK.96-071  
Amended #4a, 4/8/96, MRT, Montg. Cty. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS SMALL WELLBORN			2. Date of Death Month Day Year APRIL 03, 1996		3. Time of Death 12:30 P	
	4a. Facility Name (If not institution, give street and number) EMORY 2800 EMORY CHURCH RD.			4b. City, Town, or Location of Death Olney		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 220-40-3454		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 28, 1908		9. Birthplace (State or Foreign Country) Iowa
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Olney		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 2800 Emory Church Road			10f. Zip Code 20832		10g. Citizen of What Country? United States	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Lawrence Madison Small			18. Mother's Name (First, Middle, Maiden Surname) Lita Garland			
	19a. Informant's Name/Relationship (Type, Print) Bruce F. Wellborn / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12106 Forestvale Dr., Rockville, Maryland 20852			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date April 6, 1996		20c. Location - City or Town, State Bethesda, Maryland
	21. Signature of Funeral Service Licensee <i>Michael P. Kutto</i> M00348		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue Rockville, Maryland 20850-2805				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  MULTIPLE INJURIES COMPLICATED BY HYPOTHERMIA						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUNDED FOUND 4-3-96		28b. Time of Injury at Work? 10:45 A M 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28c. Describe how injury occurred COLD EXPOSURE FOLLOWING FALL
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>AM DIXON</i>		29c. License number OCME		29d. Date signed (Month, Day, Year) APRIL 04, 1996
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AM DIXON 111 Penn Street, Baltimore, Maryland 21201						
	31. Date filed (Month, Day, Year) APR 08 1996		32. Registrar's Signature <i>Julia Davidson Randall</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12049

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Anita Wilson			2. Date of Death Month Day Year April 7, 1996		3. Time of Death 7:45 a.m.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 157-74-6426	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 6, 1963	9. Birthplace (State or Foreign Country) Jamaica
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9320 New Hampshire Avenue			10f. Zip Code 20903		10g. Citizen of What Country? Jamaica	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed		16b. Kind of Business/Industry Childcare		
	17. Father's Name (First, Middle, Last) Arnold McIntosh			18. Mother's Name (First, Middle, Maiden Surname) Gwendolyn Chambers			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Leopold A. Wilson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cem.		Date 4-14-96	20c. Location - City or Town, State Adelphi, Maryland
	21. Signature of Funeral Service Licensee Eileen L. Rapp			22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acquired Immune Deficiency Syndrome Due to (or as a consequence of): Thrombocytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acutely Renal Failure Due to (or as a consequence of):			Approximate Interval Between Onset and Death About 3 Years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier K. Sudhakar		29c. License number D 19971		29d. Date signed (Month, Day, Year) 04/08/96
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) K. SUDHAKAR, 7610 CARROLL AVE A230, TAKOMA PARK, MD 20912							
31. Date filed (Month, Day, Year) APR 11 1996			32. Registrar's Signature John Andrew Raskin				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12050

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AMELIA A. WASHINGTON</b>						2. Date of Death Month <b>April</b> Day <b>8</b> Year <b>1996</b>		3. Time of Death <b>12:30 a.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Allegis Health Care Center</b>						4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>214-30-2140</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 25, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>605 N. Stonestreet Ave.</b>				10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>None</b>				
17. Father's Name (First, Middle, Last) <b>Frank Sewell</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Helen V. Dove</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Albert Sewell (Son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>605 N. Stonestreet Ave., Rockville, MD 20850</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Park Cem.</b>			Date <b>4/16/96</b>		20c. Location - City or Town, State <b>Rockville, MD</b>			
21. Signature of Funeral Service Licensee <i>George R. Snowden</i>						22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. asphyxiation pneumonia</b> Due to (or as a consequence of): <b>b. multiple strokes</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death <b>10 days</b> <b>yes</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>George R. Snowden</i>						29c. License number <b>D-03581</b>		29d. Date signed (Month, Day, Year) <b>April 10, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elliot R. Goldstein 9410 Old Georgetown Rd, Bethesda, Md 20814</b>											
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>			32. Registrar's Signature <i>Julia Swisher Raskin</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12051

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Carrie G White</u>				2. Date of Death Month <u>Mar.</u> Day <u>31</u> Year <u>96</u>		3. Time of Death <u>3:20 AM</u>			
	4a. Facility Name (If not institution, give street and number) <u>Holy Cross Hospital</u>				4b. City, Town, or Location of Death <u>Silver Spring</u>		4c. County of Death <u>MONTGOMERY</u>			
Funeral Director	5. Social Security Number <u>218-20-0676</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>79</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>May 23, 1916</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	Usual Residence of Decedent									
10a. State <u>MD</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Rockville</u>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <u>803 Bowie Road</u>				10f. Zip Code <u>20852</u>		10g. Citizen of What Country? <u>U.S.A.</u>				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th</u> College (1-4or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Domestic</u>		16b. Kind of Business/Industry <u>None</u>				
17. Father's Name (First, Middle, Last) <u>Andrew White</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Alice Hopkins</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Dorothy Lynn (Daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>803 Bowie Road, Rockville, MD 20852</u>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Ash Memorial Cem.</u>		Date <u>4/6/96</u>		20c. Location - City or Town, State <u>Sandy Spring, MD</u>				
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>SNOWDEN FUNERAL HOME, P.A.</u> <u>ROCKVILLE, MD 20850</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. METASTATIC BREAST CANCER</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <u>yrs</u>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>GASTROINTESTINAL HEMORRAGE</u> <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>CONGESTIVE HEART FAILURE</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Martin C. Shargel M.D.</u>		29c. License number <u>D08944</u>		29d. Date signed (Month, Day, Year) <u>Mar. 31, 1996</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MARTIN C. SHARGEL M.D.</u>				31. Date filed (Month, Day, Year) <u>APR 11 1996</u>					32. Registrar's Signature <u>[Signature]</u>	

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit




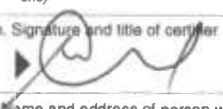
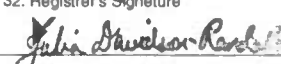
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12052

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice J. Watson</b>				2. Date of Death Month: <b>April</b> Day: <b>7</b> Year: <b>1996</b>				3. Time of Death <b>2:33 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>TAKOMA PARK</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577-60-5712</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 13, 1898</b>		9. Birthplace (State or Foreign Country) <b>MINNESOTA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>10700 KINLOCH RD.</b>				10f. Zip Code <b>20903</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MICROLOGIST</b>				16. Kind of Business/Industry <b>U.S.D.A.</b>			
	17. Father's Name (First, Middle, Last) <b>VICTOR JOHNSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE ALLEN</b>					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>JAMES S. WATSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO BOX 6612, KETCHIKAN, AK. 99901</b>					
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>4/9/96</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>MOO091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>					
	23e. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SKIDS</b> Due to (or as a consequence of): <b>b. cerebrovascular accident</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>x 3 days</b> <b>x 3 days.</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier  <b>CHITRA KANWAR MD</b>				29c. License number <b>0A1715</b>		29d. Date signed (Month, Day, Year) <b>4/8/96</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CHITRA KANWAR MD 7343 A HANOVER PARKWAY GREEN BELT, MD.</b>									
31. Date filed (Month, Day, Year) <b>APR 10 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12053

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SELMA R. WHITNEY</b>				2. Date of Death Month <b>March</b> Day <b>29</b> , Year <b>1996</b>				3. Time of Death <b>9:45 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>FOX CHASE NURSING &amp; REHABILITATION CENTER</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>				4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>577-01-6577</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 4, 1907</b>		9. Birthplace (State or Foreign Country) <b>Louisiana</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>9305 Saylorbrook Avenue</b>				10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>Joe Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vienna Robinson</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lawrence R. Whitney-Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2015 W. Mt. Harmony Road, Owings, MD 20736</b>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington University Medical Center</b>		Date <b>March 30, 1996</b>		20c. Location - City or Town, State <b>Washington, DC</b>					
	21. Signature of Funeral Service Licensee <i>Plutarco Benzon</i>				22. Name and Address of Facility <b>Columbia Mortuary Services, Inc. 225 Missouri Ave., NW, Washington, DC 20011</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Breast Cancer.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>2-3 years.</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Allen S Rogers MD</i>				29c. License number <b>041881</b>		29d. Date signed (Month, Day, Year) <b>4/1/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen S Rogers, MD 8630 Fenton St. Suite 900 Silver Spring MD 20910</b>												
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>		32. Registrar's Signature <i>Julia Davidson-Roberts</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar








96 12054

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Leola Virginia Yiannakis</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 13 1996</b>				3. TIME OF DEATH <b>13:10 M</b>			
4. SOCIAL SECURITY NUMBER <b>212-46-1870</b>		5. SEX <b>1 M 2 F</b>	6. AGE (In yrs. last birthday) <b>48</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>April 6, 1947</b>		8. BIRTHPLACE (State or Foreign Country) <b>Baltimore, Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Kent and Queen Anne's Hospital Inc.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Chestertown MD</b>			9c. COUNTY OF DEATH <b>Kent County</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Kent</b>		10c. CITY, TOWN OR LOCATION <b>Betterton</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>23 Main Street</b>				10f. ZIP CODE <b>21610</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11 Elementary/Secondary (0-12) College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk, Clerical</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Painting</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Frank Rolison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen May Dells</b>							
19a. INFORMANT'S NAME (Type/Print) <b>James E. Yiannakis, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23 Main Street, Betterton, Maryland 21610</b>							
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Still Pond Cemetery/March 16, 1996</b>			20c. LOCATION — City or Town, State <b>Still Pond, Maryland</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Fellows, Helfenbein, &amp; Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HEPATIC ENCEPHALOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. METASTATIC BREAST CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>3 days</b> <b>9 mo.</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>									
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D41587</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/14/96</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Helen A. Noble, MD, 122 Speer Road, Chestertown, Maryland 21620</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 14 '96</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12055**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arousiaq Yacoubian</b>				2. Date of Death Month <b>April</b> Day <b>4</b> Year <b>1996</b>				3. Time of Death <b>2:00 PM</b>					
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Potomac</b>				4b. City, Town, or Location of Death <b>Potomac</b>				4c. County of Death <b>Montgomery</b>					
Funeral Director	5. Social Security Number <b>133.42.1799</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>March 20, 1908</b>		9. Birthplace (State or Foreign Country) <b>Kharput, Turkey</b>	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>9101 McDonald Drive</b>						10f. Zip Code <b>20817</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>					
	17. Father's Name (First, Middle, Last) <b>A. Kinosian</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Hripsineh Unknown</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jean Yacoubian, M.D.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9101 McDonald Drive Bethesda, Md. 20817</b>									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Comfort Crematory</b>				Date <b>4/6/96</b>		20c. Location - City or Town, State <b>Alexandria, Va.</b>			
	21. Signature of Funeral Service Licensee <i>John M. Peters</i>				22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>sepsis</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>intest. abdominal crisis</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>hours</b>													
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypertension</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>David A. Blass MD</i>				29c. License number <b>D23911</b>		29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David A. Blass, M.D. 9410 Old Georgetown Road Bethesda, MD 20814</b>													
	31. Date filed (Month, Day, Year) <b>APR 08 1996</b>				32. Registrar's Signature <i>John Swisher Raskala</i>									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



96 12056

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mesfin Yohannes</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>4</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>8:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>579-76-6878</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 29, 1950</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ethiopia</b>		9a. FACILITY NAME (If not institution, give street and number) <b>8201 16th Street, #603</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>8201 16th Street, #603</b>			
10f. ZIP CODE <b>20910</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>African American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supply Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Yohannes Theodros</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Workababa Dubale</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Siefe Yohannes</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10221 Green Holly Terrace, Silver Spring, MD 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Gate of Heaven Cemetery 4/6/96</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>		22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS COMPLEX</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  <b>Diabetes Mellitus</b>  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 21642</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/14/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SISSAY AWOKÉ 3333 University Blvd #408 Kensington 20887</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

8

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12057

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thelma Zimmerman</i>				2. DATE OF DEATH MONTH DAY 1996 <i>March 26 1996</i>		3. TIME OF DEATH <i>10:35A M</i>	
4. SOCIAL SECURITY NUMBER 215-01-2926		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 1, 1910	
8a. FACILITY NAME (If not institution, give street and number) NATIONAL LUTHERAN HOME				8b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		8c. COUNTY OF DEATH MONTGOMERY CO.	
9a. STATE MD.				9b. COUNTY BALTIMORE CITY		9c. CITY, TOWN OR LOCATION BALTIMORE	
10a. STREET AND NUMBER 17 - W. FORT AVENUE				10b. ZIP CODE 21230		10c. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TYPIST-CLERK		16b. KIND OF BUSINESS/INDUSTRY BALT. GAS & ELECTRIC			
17. FATHER'S NAME (First, Middle, Last) LOUIS V. ZIMMERMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SCHAUM			
19a. INFORMANT'S NAME (Type/Print) REV. DR. REICHARD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN CEMETERY 4/1		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.H. Hyson</i>				22. NAME AND ADDRESS OF FACILITY HYSONG CO., INC. 1300- N ST., NW, WASH., DC			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Carcinoma</i> Approximate Interval Between Onset and Death <i>Month</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel H. Galler MD</i>				29c. LICENSE NUMBER 033138		29d. DATE SIGNED (Month, Day, Year) 3/26/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel H. Galler MD 12850 Middlebrook Rd Germantown, MD							
31. DATE FILED (Month, Day, Year) APR 04 1996				32. REGISTRAR'S SIGNATURE <i>Jobi Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Submitted by: [illegible] 2007, 10/1/07



96-2011-510  
UNK.#96-081  
CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12058

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KEVIN Sean ASBELL				2. Date of Death Month Day Year APRIL 15, 1996		3. Time of Death 2349PM	
	4a. Facility Name (If not Institution, give street and number) 1600 EAST MONUMENT STREET ALLEY				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a	
Funeral Director	5. Social Security Number 213-70-2012		6. Sex XX M 2 F		7. Age (in yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 6, 1958	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No				10e. Street and Number 1634 E. CHASE STREET		10f. Zip Code 21213	
	10g. Citizen of What Country? UNITED STATES				11. Marital Status XX Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: unk. airforce	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) -	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry various places			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) WILLIAM E. ASBELL				18. Mother's Name (First, Middle, Maiden Surname) PEARL DOWDY			
	19a. Informant's Name/Relationship (Type, Print) PEARL MAEBELL HAYNES				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 GOODLUCK RD., LANHAM, MD 20706			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Location - City or Town, State 4-26 RANDALLSTOWN, MD	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility wm. c. march fh.-1101 E. NORTH AVENUE			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 Yes 2 No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE				27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			
	28a. Date of Injury (Month, Day, Year) 4-15-96				28b. Time of Injury 2330 p M		28c. Injury at Work? 1 Yes 2 No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred subject shot				28e. Location (Street and Number or Rural Route Number, City or Town, State) 1600 Blk. E. Monument St Baltimore City, Md			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dennis J. Chute MD			
To Be Completed by Physician/Medical Examiner	29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) APRIL 16, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) APR 25 1996			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature [Signature]				33. Registrar's Title [Title]			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



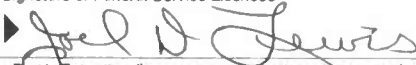
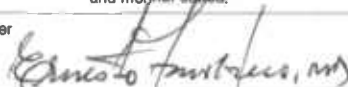
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12059

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>DR. OSCAR ABOSCH</b>				2. Date of Death Month <b>APRIL</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>2.50 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL / SUBACUTE UNIT</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>			
Funeral Director	5. Social Security Number <b>214-76-0109</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAR. 31, 1939</b>	9. Birthplace (State or Foreign Country) <b>ARGENTINA</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. Street and Number <b>6 TROTTERS CT., APT. 204</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>THORASIC &amp; CARDIOVASCULAR SURGEON</b>			16b. Kind of Business/Industry <b>MEDICINE</b>		
	17. Father's Name (First, Middle, Last) <b>NUTA AARON ABOSCH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELLA UNKNOWN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. ESTELA ABOSCH</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3405 JANELLEN DR. BALTIMORE, MD 21208</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HAR SINAI</b>		Date <b>4/24/96</b>		20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CARCINOMATOSIS, GASTRIC</b> Due to (or as a consequence of): b. <b>ADENOCARCINOMA, GASTRIC (LINITIS PLASTICA)</b> Due to (or as a consequence of): c. <b>-</b> Due to (or as a consequence of): d. <b>-</b>								Approximate Interval Between Onset and Death <b>4 MONTHS</b> <b>1 1/2 YEARS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>NO</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SUBACUTE UNIT / 254</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>N/A</b>		28b. Time of Injury <b>N/A</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>N/A</b>		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D16333</b>		29d. Date signed (Month, Day, Year) <b>APRIL 23, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERNESTO MOLFINO MD 2918 MONTCLAIR DRIVE. ELICOTT CITY - MD 21043</b>										
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12060

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy May ADAMS</b>						2. Date of Death Month Day Year <b>April 23, 1996</b>		3. Time of Death <b>3:30 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore County</b>	
Funeral Director	5. Social Security Number <b>216-09-6253</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 18, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>9319 Perglen Road</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Church</b>			
17. Father's Name (First, Middle, Last) <b>Albert Wilford, Jr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Hinkle</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Wilford Adams (son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9319 Perglen Road, Baltimore, MD 21236</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. Location - City or Town, State <b>4/25/96 Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cerebral Bleed</b> Due to (or as a consequence of):  b. <b>Hypertension</b> Due to (or as a consequence of):  c. <b>Anticoagulation</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>10 hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  M.D.		29c. License number <b>D 47813</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bashar Karakash, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>										
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12061

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NORMAN B. ANSELL</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>8:05am</b>											
	4a. Facility Name (If not institution, give street and number) <b>CROMWELL CENTER NURSING HOME (MERIDIAN)</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>											
Funeral Director	5. Social Security Number <b>215-10-6179</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 6, 1916</b>											
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>21 TENTMILL LANE, APT. G</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAIL CARRIERS Carrier</b>		16b. Kind of Business/Industry <b>U.S. POSTAL SERVICE</b>													
	17. Father's Name (First, Middle, Last) <b>JOSEPH P. ANSELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVA MARGOLIS</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>MR. PHIL ANSELL (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1124 CEDARCROFT RD. BALTIMORE, MD 21239</b>													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH TFILOH -</b>		Date <b>4/24/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>											
	21. Signature of Funeral Service Licensee <b>Ellenue Lewmon</b>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>1 WEEK</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. <b>Pneumonia</b> Due to (or as a consequence of):</td> <td><b>1 WEEK</b></td> </tr> <tr> <td>c. <b>Multi-Infarct Dementia</b> Due to (or as a consequence of):</td> <td><b>1 YEAR</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1 WEEK</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Pneumonia</b> Due to (or as a consequence of):	<b>1 WEEK</b>	c. <b>Multi-Infarct Dementia</b> Due to (or as a consequence of):	<b>1 YEAR</b>	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>1 WEEK</b>															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. <b>Pneumonia</b> Due to (or as a consequence of):	<b>1 WEEK</b>																
	c. <b>Multi-Infarct Dementia</b> Due to (or as a consequence of):	<b>1 YEAR</b>																
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Frontal Lobe Syndrome</b> <b>Diabetes Mellitus</b> <b>ASCVD</b>																		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <b>Fredrick Sirkis M.D.</b>				29c. License number <b>D 22645</b>		29d. Date signed (Month, Day, Year) <b>4/22/96</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FREDRICK SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</b>																		
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <b>John D. Smith</b>														

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BONNIE CLAYTON BROOKS				2. DATE OF DEATH MONTH DAY YEAR APRIL 13 1996		3. TIME OF DEATH 4:30 P M	
4. SOCIAL SECURITY NUMBER 217-44-2151		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-29-1947	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) WESLEYAN HEALTH CARE CENTER		9b. CITY, TOWN OR LOCATION OF DEATH DENTON	
9c. COUNTY OF DEATH CAROLINE				10a. STATE MARYLAND			
10b. COUNTY DORCHESTER				10c. CITY, TOWN OR LOCATION CAMBRIDGE			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1300 HAMBROOKS BLVD			
10f. ZIP CODE 21613				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMPUTER PROGRAMMER		16b. KIND OF BUSINESS/INDUSTRY PROCESSING	
17. FATHER'S NAME (First, Middle, Last) CLAYTON BROOKS				18. MOTHER'S NAME (First, Middle, Maiden Surname) PAMELIA WEAVER			
19a. INFORMANT'S NAME (Type/Print) PAMELIA BROOKS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 HAMBROOKS BLVD CAMBRIDGE, MD 21613			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade, Dir.</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Mesothelioma lung CA</i>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G.D. Sprouse</i>				29c. LICENSE NUMBER D32036		29d. DATE SIGNED (Month, Day, Year) 4/16/96	
30. NAME AND ADDRESS OF PHYSICIAN WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GARY SPROUSE 2108 RED APPLE PLAZA CHESTER, MD 21619							
31. DATE FILED (Month, Day, Year) APR 25 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

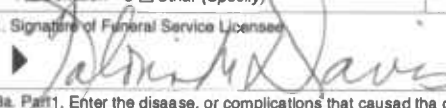
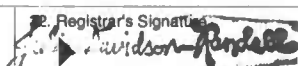
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 12063

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MYRTLE E. BAYLOR</b>				2. Date of Death Month Day Year <b>APRIL 21 1996</b>		3. Time of Death <b>5.10 pm</b>				
	4e. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>217-07-9268</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96 yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 7, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>9109 Liberty Road</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>Someone Else's Home</b>			
	17. Father's Name (First, Middle, Last) <b>Christopher Green</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Hester</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Frederick White</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1409 Hadwick Drive Apt. L, Baltimore, MD 21221</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Memorial Gardens 4-25 Dundalk, MD</b>								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPTICEMIA</b> Due to (or as a consequence of): <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD						29c. License number <b>45045</b>		29d. Date signed (Month, Day, Year) <b>APRIL 21 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. A. G. B. O. Z. U. NORTHWEST HOSP CENTER, BALTO. MD</b>											
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint, mostly illegible text covering the main body of the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12064

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTHER Murphy BROWN</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>9:36 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-07-4595</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 1 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>731 B1 Camberley Circle</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>David Anderson Murphy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Virginia Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert A. Brown/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13007 Talisman Rd., Reisterstown, MD 21136</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>4/25/96 Catonsville, MD</b>		
21. Signature of Funeral Service Licensee <b>Lowell M. Lemmon</b>				22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Coronary, Lung</i></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								Approximate Interval Between Onset and Death <b>2 hrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. G. G. G. G.</b>				29c. License number <b>D-12980</b>		29d. Date signed (Month, Day, Year) <b>4/25/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JAMES QUINLAN, MD 7801 YORK RD TOWSON MD 21204</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <b>Julia [Signature]</b>				

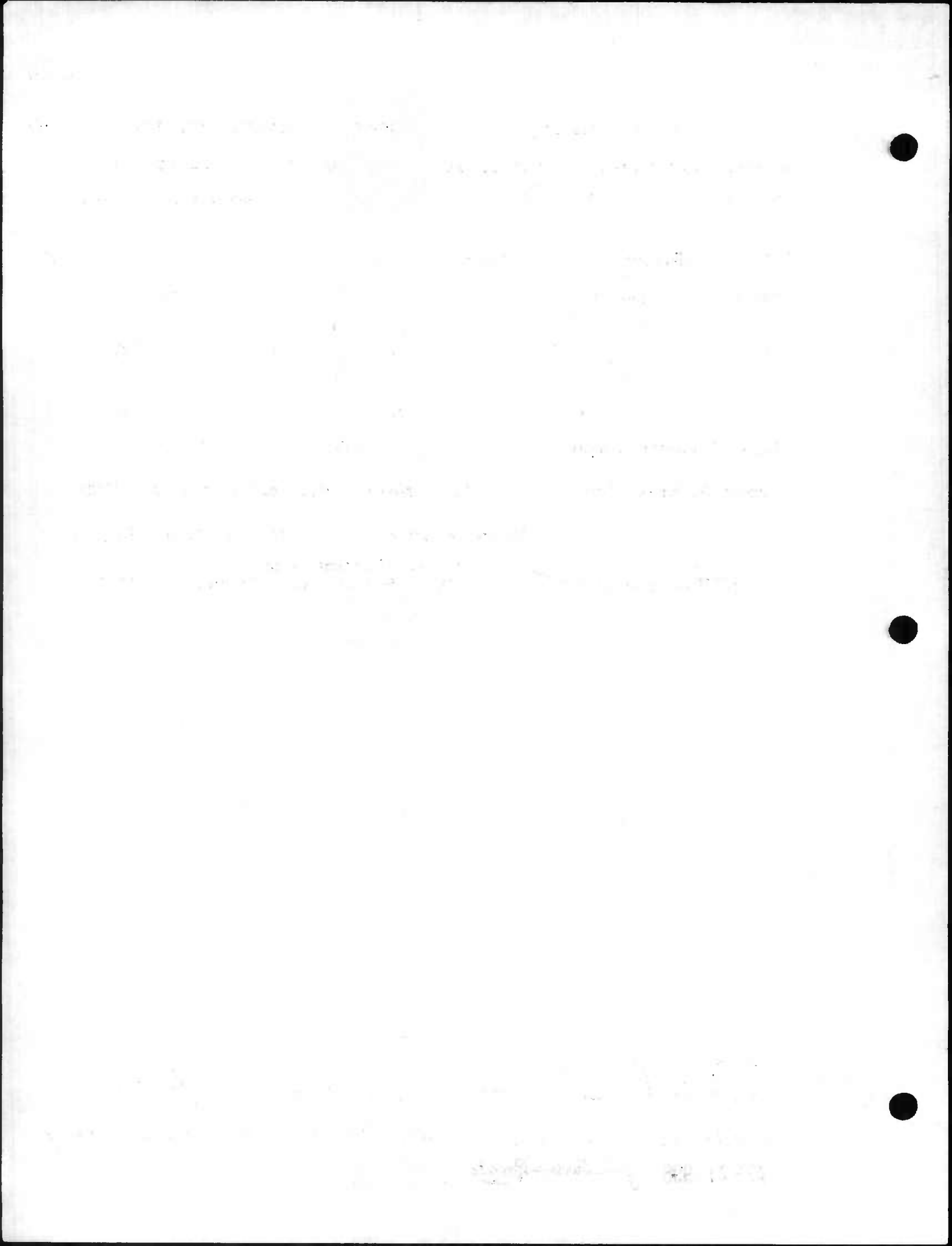
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



ITEMS: 23 PART I,  
FILM G-735 5/2/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

PER MEO State of Maryland / Department of Health and Mental Hygiene

96 12065

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYLER JACOB BURMAN						2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 12:29 PM	
	4a. Facility Name (If not institution, give street and number) ST. JOSEPH HOSPITAL						4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-45-9157		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 2 MOS Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 19, 1996		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location Parkville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8 Palma Court				10f. Zip Code 21234		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a			16b. Kind of Business/Industry n/a			
	17. Father's Name (First, Middle, Last) Unknown by Informant						18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Leigh Burman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elizabeth Burman (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Palma Court, Balto., MD 21234					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 24 APR		20c. Location - City or Town, State Parkville, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SUDDEN INFANT DEATH SYNDROME Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPITAL			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 21, 1996			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) APR 25 1996									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

APR 22 1968



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12066

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>George L. Brill</u>				2. Date of Death Month <u>April</u> Day <u>22</u> , Year <u>1996</u>		3. Time of Death <u>3:55 P</u>		
	4a. Facility Name (If not institution, give street and number) <u>Riverview Nursing Centre, Inc.</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore</u>		
Funeral Director	5. Social Security Number <u>212-22-4558</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>94</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Jan. 11, 1902</u>		
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10. Usual Residence of Decedent 10a. State <u>Maryland</u> 10b. County <u>N/A</u> 10c. City, Town or Location <u>Baltimore</u> 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4or 5+) <u>College</u>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Owner</u>		16b. Kind of Business/Industry <u>Cleaning Cloth Company</u>	
17. Father's Name (First, Middle, Last) <u>John Brill</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Josephine Fornoff</u>				19. Informant's Name/Relationship (Type, Print) <u>J. Stanley Wheeler (Nephew)</u>	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		20c. Location - City or Town, State <u>4/24/96 Baltimore, Maryland</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>	
22. Name and Address of Facility <u>Schmunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213</u>				23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>CARDIO RASPT ARREST</u> Due to (or as a consequence of): <u>Coln</u> Due to (or as a consequence of): <u>Chronic Dysphagia with Esophageal STRICTURE</u> Due to (or as a consequence of): <u>Smoking</u>				Approximate Interval Between Onset and Death <u>(1hr)</u> <u>&gt; 5 yr.</u> <u>&gt; 5 yr.</u> <u>2-3 yr.</u>	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D 14221</u>	
29d. Date signed (Month, Day, Year) <u>4.23.96</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>T. A. Krowl 225 E. Blvd BALT MD 21221</u>				31. Date filed (Month, Day, Year) <u>APR 25 1996</u>	
32. Registrar's Signature <u>[Signature]</u>				33. Registrar's Title <u>[Signature]</u>				34. Registrar's Name <u>[Signature]</u>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96-1867-003

B.K.S ITEMS: 23 PART I, II,

27, 28a-f, PER MEO FILMG-734  
4/25/96 t,t

Item 1 4-26-96 Film G734 W.H. Per Antomy B.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12067

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH A. BURNS -Quinn

2. Date of Death

Month Day Year  
APRIL 07, 1996

3. Time of Death

1207 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL GENERAL HOSPITAL E.R.

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

144-42-0910

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 9, 1945

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State  
Maryland Anne Arundel

10b. County

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1138 Cove Road

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 thCollege (1-4 or 5+)  
2 yrs.16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Rasmussen Group

17. Father's Name (First, Middle, Last)

George W. Modrow

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Kanakes

19a. Informant's Name/Relationship (Type, Print)

Meredith Quinn/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1138 Cove Road-Annapolis, Maryland 21403

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

State Anatomy board-655 W. Baltimore Street  
Baltimore, Maryland 21201-155923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

## ACUTE AMITRIPTYLINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☒ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)  
FOUND 4-7-96

28b. Time of

FOUND AT  
11:30 A M

28c. Injury at

Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

SUBJECT TOOK DRUG

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

1138 COVE ROAD

ANNAPOLIS, MARYLAND

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL, 8, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mrs. Dalia J. Bischer</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>22</i> YEAR <i>96</i>		3. TIME OF DEATH <i>4:15 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-10-3527-D</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>91</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5-13-04</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Germany</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Horizon Specialty Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore MD</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>MD</i>			
10b. COUNTY <i>N/A</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1300 S. Silters</i> <i>3550 Lyndale Ave</i>			
10f. ZIP CODE <i>21213</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Wilhelm Dell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Josephine Brunner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Clara Kouba (daughter)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1204 Mill Creek Rd., Fallston, MD 21047</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gardens of Faith Cem. 4/24</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>ALTHENIA Disson</i> b. <i>ARTERIO Sclerosis</i> c. <i>Hypertension</i> d. <i>P.E.G. Aortic Stenosis</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>P.E.G. Aortic Stenosis</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D 24276</i>		29d. DATE SIGNED (Month, Day, Year) <i>4.23.96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Simon Scalia, 2900 E. Baltimore St., Baltimore, MD 21224</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1996</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12069

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gene Edward Beadenkopf, Sr.				2. Date of Death Month April 22, 1996 Day Year		3. Time of Death 8:45 am	
	4a. Facility Name (If not institution, give street and number) 2000 Breitwert Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-52-1608		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 2, 1948	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2000 Breitwert Avenue				10f. Zip Code 21230		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1973/1975		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Banking		
17. Father's Name (First, Middle, Last) Arthur Roland Beadenkopf				18. Mother's Name (First, Middle, Maiden Sumame) Frances Hands				
19a. Informant's Name/Relationship (Type, Print) Darlene Patricia Huskey P.R./Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Grayhaven Ct. Dundalk, MD 21222				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 04/23/96		20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee George E. MacNabb				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1995
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non insulin dependent diabetes						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Marie A. Dolynko MD				29c. License number MD DZ 9923		29d. Date signed (Month, Day, Year) 4/23/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2822 Hollins Ferry Road Baltimore, Md. 21230								
31. Date filed (Month, Day, Year) APR 25 1996				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar







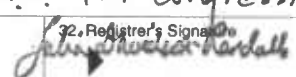
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12070

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Henry Burkhardt</b> <del>WILLIAM BURKHART</del>				2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>2:45 PM</b>										
	4a. Facility Name (If not institution, give street and number) <b>BETHESDA SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>										
Funeral Director	5. Social Security Number <b>212-10-9988</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02/01/1910</b>										
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>										
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
	10e. Street and Number <b>2413 ARBUTON AVENUE</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.A.</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>N/A</b>		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR</b>		16b. Kind of Business/Industry <b>CROWN CENTRAL PETROLEUM</b>												
	17. Father's Name (First, Middle, Last) <b>GEORGE BURKHART</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LOTTIE SCHEIB</b>												
	19e. Informant's Name/Relationship (Type, Print) <b>DELORES L. CHAPPELL</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8060 WOODHOLME CIRCLE, PASADENA, MD 21122</b>												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MARYLAND</b>										
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME</b> <b>1 SECOND AVENUE S.W., GLEN BURNIE, MARYLAND 21061</b>												
	23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Cerebro-Vascular Accident</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>5 days</b></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Cerebro-Vascular Accident</b>	Approximate Interval Between Onset and Death <b>5 days</b>	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Cerebro-Vascular Accident</b>	Approximate Interval Between Onset and Death <b>5 days</b>														
	b.	Due to (or as a consequence of):															
	c.	Due to (or as a consequence of):															
	d.	Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D37891</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22 1996</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. RAJVANSHI M.P. 121 Congressional Ln #409 Rockville MD 20852</b>																	
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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ITEMS: 23 PART I, 27, PER MEO

State of Maryland / Department of Health and Mental Hygiene

96 12071

FILM G-734 4/29/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARYL F. BROOKS				2. Date of Death Month Day Year APRIL 17 1996		3. Time of Death 5:22 P.M.	
	4a. Facility Name (If not institution, give street and number) 32 ENCHANTED HILLS ROAD				4b. City, Town, or Location of Death OWINGS MILLS		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-58-5021		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Jun. 25, 1952	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 5512 Northwood Drive		10f. Zip Code 21212		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labirer		16b. Kind of Business/Industry Sears			
	17. Father's Name (First, Middle, Last) Melvin Brooks		18. Mother's Name (First, Middle, Maiden Surname) Edith Vann		19a. Informant's Name/Relationship (Type, Print) Donald Brooks		19b. Mailing Address (Rural Route Number, City or Town, State, Zip Code) Woods 9519 Watham Road, Baltimore, MD 21234	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park Cemet		20c. Location - City or Town, State 4-22-96 Randallstown, MD		21. Signature of Funeral Service Licensee Bernard D. Johnson	
	22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY ALCOHOLISM Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death X <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Margaret A. Korson		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 18, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret A. Korson		31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature John A. R. R. R.		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12072

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT

BURNEY

2. Date of Death

Month Day Year  
APRIL 22, 1996

3. Time of Death

8:10 P.M.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

265-79-6365

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

31 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 24, 1964

9. Birthplace (State or Foreign Country)

FL.

Usual Residence of Decedent

10a. State

MD.

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2300 Round Rd. Apt T1

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10<sup>th</sup>

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

Tyronne Burney

18. Mother's Name (First, Middle, Maiden Surname)

Alma Davis

19a. Informant's Name/Relationship (Type, Print)

Edmund R. Demeritte

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2608 Maryland Ave Apt 1 Baltimore, MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MNT. ZION Ceme.

Date

4-27-96

20c. Location - City or Town, State

Lansdowne, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylie FH PA

638 N. Gilmer St.

21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brainstem herniation

one day

Due to (or as a consequence of):

b. Bilateral basal ganglion masses

one month

Due to (or as a consequence of):

c. Acquired Immunodeficiency Syndrome

one year

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Lewis MD

29c. License number

M6321

29d. Date signed (Month, Day, Year)

April 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Lewis Johns Hopkins Hospital Baltimore Maryland

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation

$$f(x) = \int_0^x f(t) dt$$

It is shown that the function  $f(x)$  is continuous and differentiable at every point  $x$  of the interval  $[0, 1]$ .

2. In the second part of the paper, we consider the problem of the existence of solutions of the system of differential equations

$$\frac{dx}{dt} = P(x, y, z), \quad \frac{dy}{dt} = Q(x, y, z), \quad \frac{dz}{dt} = R(x, y, z)$$

where  $P, Q, R$  are continuous functions of  $x, y, z$  in the region  $G$  of the three-dimensional space.

It is shown that if the functions  $P, Q, R$  satisfy certain conditions, then the system of equations has a unique solution in the region  $G$ .

3. In the third part of the paper, we consider the problem of the stability of the solutions of the system of differential equations

$$\frac{dx}{dt} = P(x, y, z), \quad \frac{dy}{dt} = Q(x, y, z), \quad \frac{dz}{dt} = R(x, y, z)$$

with respect to the initial conditions. It is shown that if the functions  $P, Q, R$  satisfy certain conditions, then the solutions are stable.

4. In the fourth part of the paper, we consider the problem of the existence of periodic solutions of the system of differential equations

$$\frac{dx}{dt} = P(x, y, z), \quad \frac{dy}{dt} = Q(x, y, z), \quad \frac{dz}{dt} = R(x, y, z)$$

where  $P, Q, R$  are continuous functions of  $x, y, z$  in the region  $G$  of the three-dimensional space.

It is shown that if the functions  $P, Q, R$  satisfy certain conditions, then the system of equations has a periodic solution.

5. In the fifth part of the paper, we consider the problem of the existence of solutions of the system of differential equations

$$\frac{dx}{dt} = P(x, y, z), \quad \frac{dy}{dt} = Q(x, y, z), \quad \frac{dz}{dt} = R(x, y, z)$$

where  $P, Q, R$  are continuous functions of  $x, y, z$  in the region  $G$  of the three-dimensional space.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12073

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Michael Cavanaugh

2. Date of Death

Month

Day

Year

Apr

23

96

3. Time of Death

8:20 am

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-22-4122

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 19, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4146 Wilkens Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

supervisor

16b. Kind of Business/Industry

paper company

17. Father's Name (First, Middle, Last)

Leo M. Cavanaugh

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Cavanaugh

19e. Informant's Name/Relationship (Type, Print)

Mildred Cavanaugh, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4146 Wilkens Avenue Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery 4/26/96 Brooklyn, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne

2719 Hammonds Ferry Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure, Pulmonary Edema

Due to (or as a consequence of):

Acute + Chronic Renal Failure

Due to (or as a consequence of):

Diabetic Nephrosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

day 2

2 weeks

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Upper Gastrointestinal Bleeding

Nephrotic Syndrome

Hyperinsulin Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D 19558

29d. Date signed (Month, Day, Year)

4-23-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON Avenue BALTIMORE, MARYLAND 21229

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

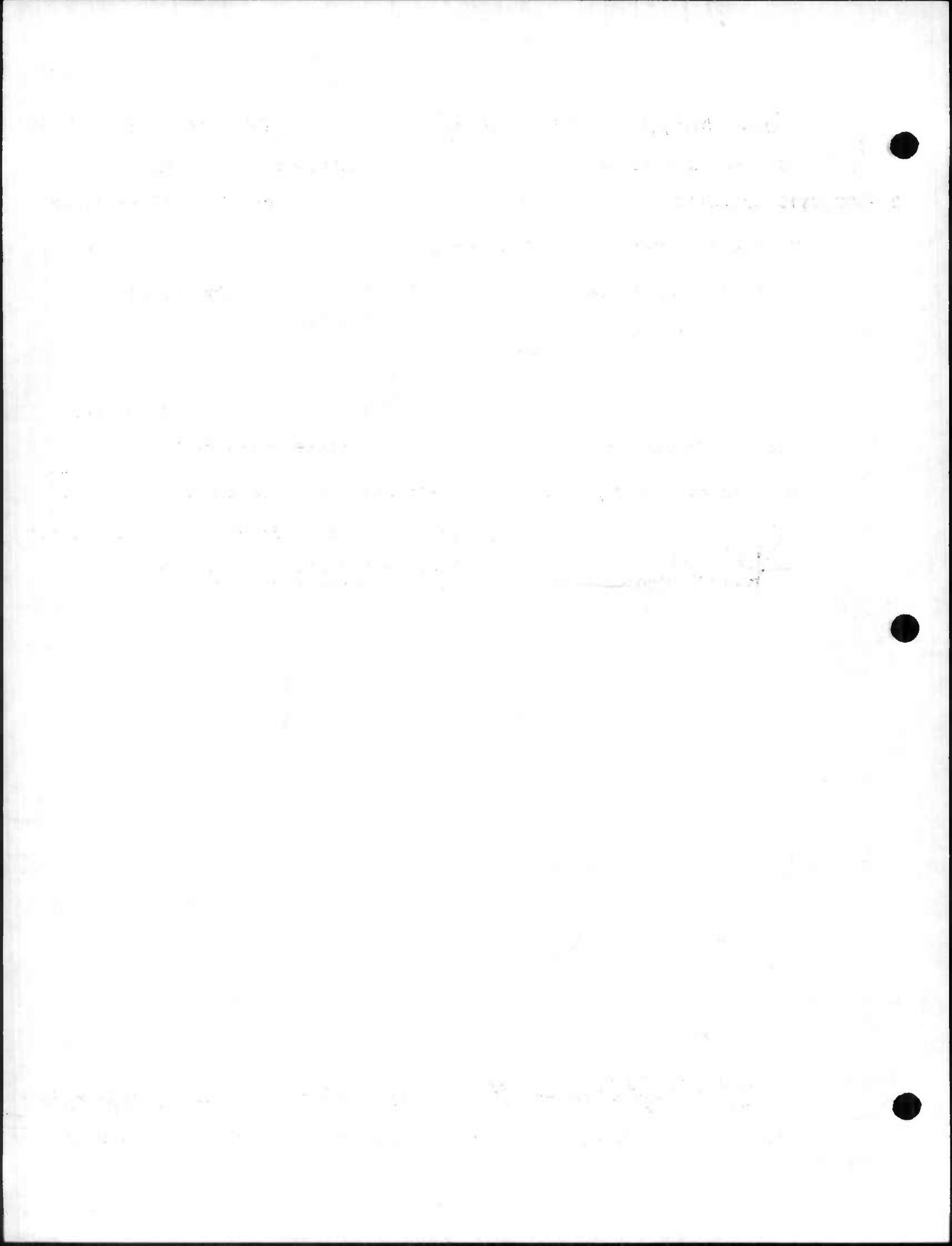
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





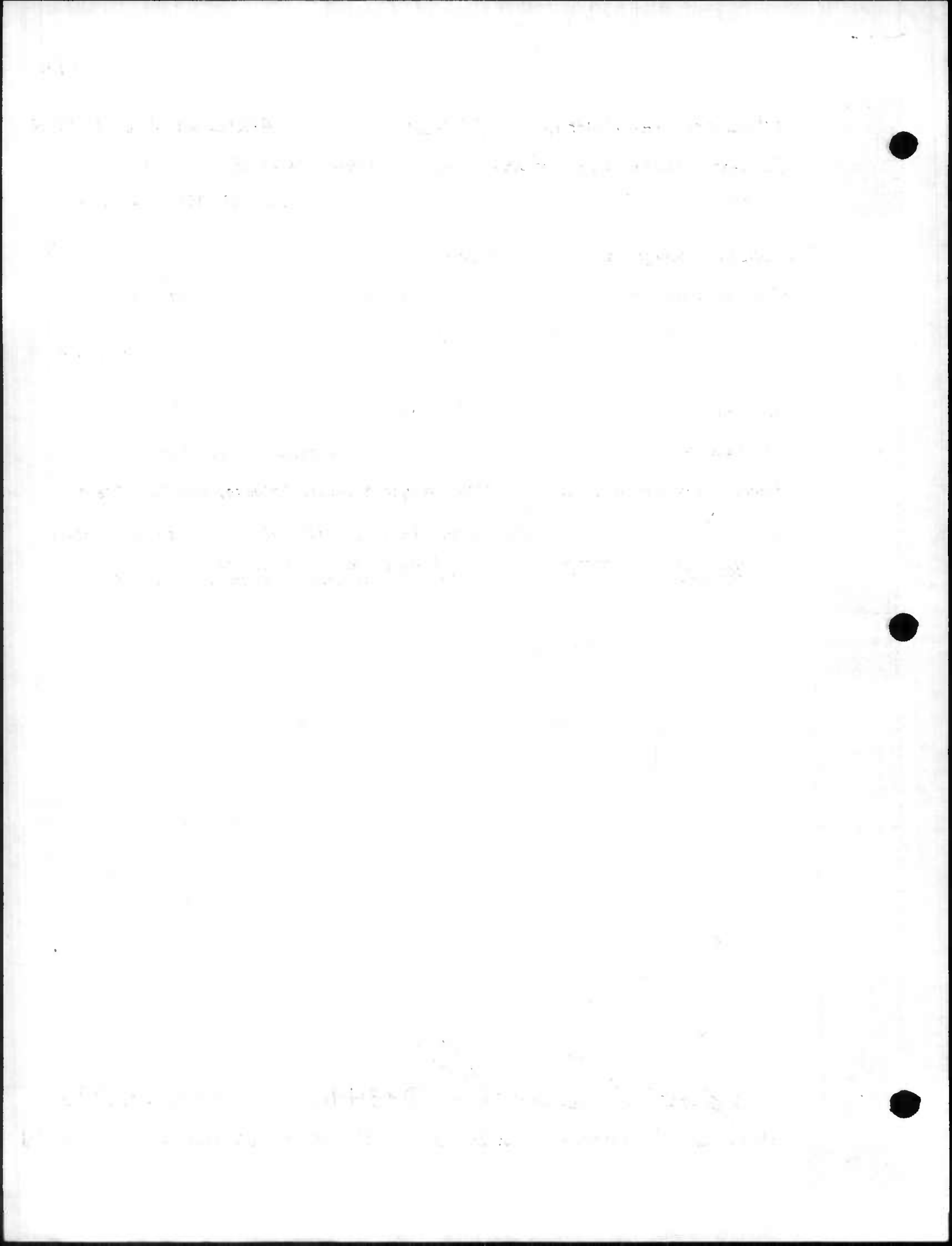
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12074

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marcos Tolentino Barcenas Chamorro</b>				2. Date of Death Month <b>APRIL</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>11:13AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>14</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 30, 1981</b>		
	9. Birthplace (State or Foreign Country) <b>Nicaragua</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7710 Fontaine Street</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>Nicaragua</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>			
15. Decedent's Education (Specify only highest grade completed) <b>8th Grade</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>Jose Barcenas</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Claudia L. Chamorro</b>		19. Informant's Name/Relationship (Type, Print) <b>Claudia Chamorro (Mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7710 Fontaine Street, Potomac, Maryland 20854</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory 4/22/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <b>Matthew [Signature]</b>		22. Name and Address of Facility <b>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. <b>HYPOXIA</b> Due to (or as a consequence of):  b. <b>Hyperviscosity</b> Due to (or as a consequence of):  c. <b>Acute Lymphoblastic Leukemia</b> Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death <b>24 hours</b> <b>6 days</b> <b>5 years 7 months</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>APR 25 1996</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Alan D. Friedman</b>		29c. License number <b>D33490</b>		29d. Date signed (Month, Day, Year) <b>APRIL 21, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan D. Friedman, MD Johns Hopkins Hospital Baltimore, Maryland</b>	
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>[Signature]</b>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12075

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DOMINIC JOSEPH CALVANO

2. Date of Death

Month Day Year  
APRIL 23, 1996

3. Time of Death

9:26 A.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-01-9400

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
April 6, 1909

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1014 Reverdy Road

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemical Operator

16b. Kind of Business/Industry

Chemical Company

17. Father's Name (First, Middle, Last)

Joseph Calvano

18. Mother's Name (First, Middle, Maiden Surname)

Liberata DiLello

19a. Informant's Name/Relationship (Type, Print)

Nicholas J. Calvano/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7427 Old Washington Road Woodbine, MD. 21797

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

4/26/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.  
5305 Harford Road Baltimore, Maryland 21214

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. COLON CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER METASTASES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospice:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kendall Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

4/23/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

Kendall Faulkner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



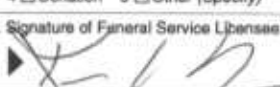

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12076

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK J. COWAN, Jr.</b>				2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>09:47 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-14-2233</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 30, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore (Baltimore Highlands)</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>2922 New York Avenue,</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW 2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Funeral Director</b>			16b. Kind of Business/Industry <b>Funeral Home Owner</b>	
17. Father's Name (First, Middle, Last) <b>Frank J. Cowan, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Hoffman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Paul P. Gentile, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2922 New York Ave., Balto., Md. 21227</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>			20c. Location - City or Town, State <b>Apr 26, '96 Baltimore, Md.</b>		
21. Signature of Funeral Service Licensee  <b>Kevin E. Ecker</b>				22. Name and Address of Facility <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225-1856</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>cardiogenic shock</b> Due to (or as a consequence of):  b. <b>myocardial infarction</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate interval Between Onset and Death  <b>12 hours</b>  <b>5 days</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Sepsis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>N2474</b>		29d. Date signed (Month, Day, Year) <b>April, 22nd, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Abenaa Brewster Johns Hopkins Hospital</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12077

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN COLEMAN</b>						2. Date of Death Month <b>APRIL</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>06:45 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>						4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>219-07-9729</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 9, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lochearn</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3609 Oak Avenue</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Baltimore County Board of Education</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Henry Ray</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie Lee Williams</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Charles Sommer (Nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2112 Country Fare Lane Sykesville, MD 21784</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evangelical Lutheran Cem.</b>		Date <b>Apr 25</b>		20c. Location - City or Town, State <b>Shrewsbury, PA</b>			
	21. Signature of Funeral Service Licensee <i>Stephen M Jenkins</i>				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PROBABLE ACUTE MYOCARDIAL INFARCTION 8-comin</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Osteoporosis</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Davidson</i> <b>HOUSE PHYSICIAN</b>		29c. License number <b>D 40390</b>		29d. Date signed (Month, Day, Year) <b>APRIL 21, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N.W. HOSPITAL CTR, 5401 OLD COURT RD, RANDALLSTOWN, MD 21133</b>									
	31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <i>Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12078

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VERA DZIENNIK</b> Vera Kathryn Dziennik				2. Date of Death Month Day Year <b>4 20 96</b>		3. Time of Death <b>5:10 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MD.</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-28-2276</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 16, 1928</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>3439 Kenyon Avenue</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Heiliger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Baldwin</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Julia Bonner (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3213 Woodring Avenue, Baltimore, Maryland 21234</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>4-23 Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213</b>			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC COLON CARCINOMA</b>							
	23b. Approximate interval between Onset and Death <b>2 YRS.</b>							
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D 41410</b>		29d. Date signed (Month, Day, Year) <b>April 20th, 96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOGINDER P. MEHTA ST. JOSEPH MEDICAL CENTER TOWSON, MD.</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

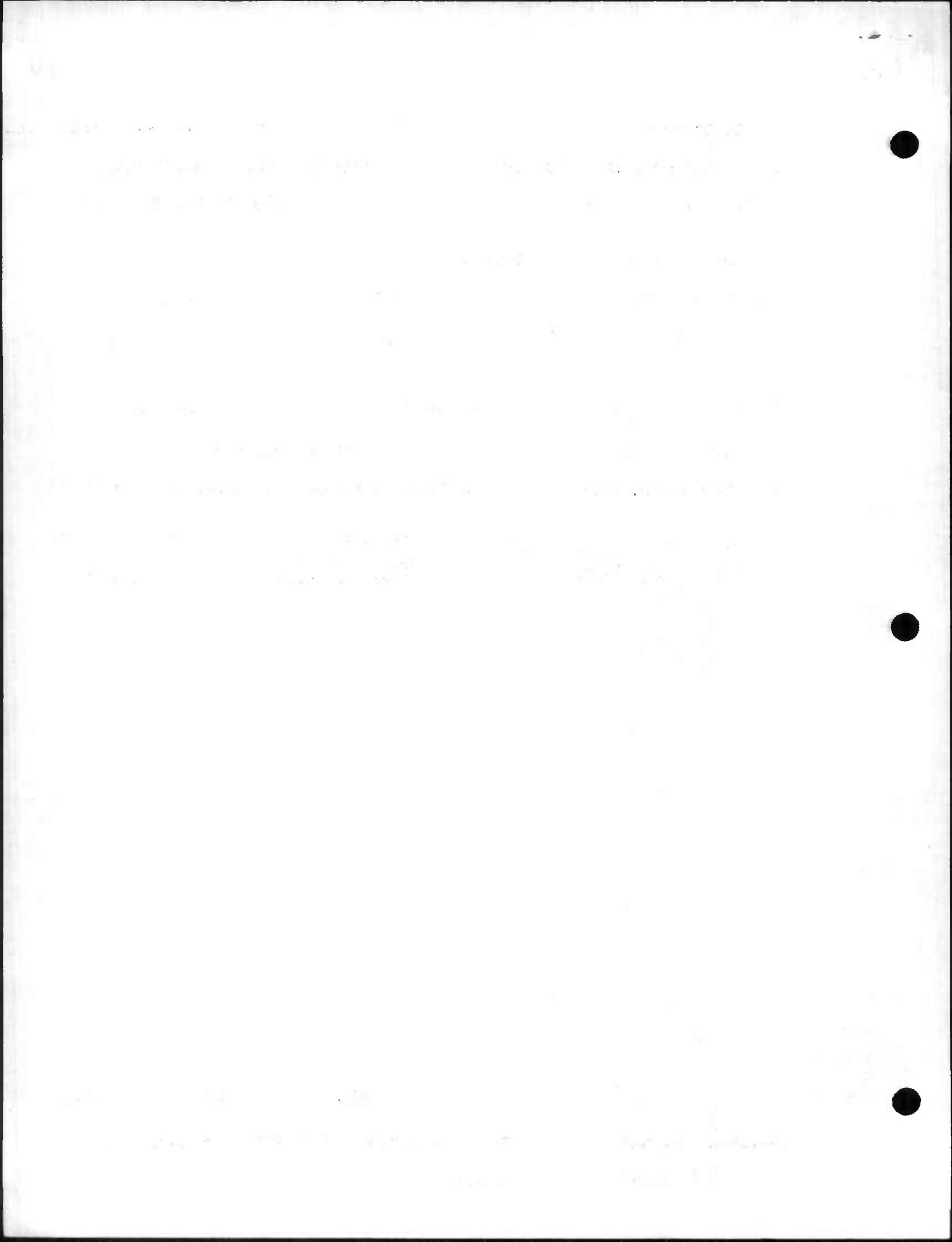
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and duly filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12079

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Keener</b> <b>BASIL KEENER DORSEY, JR</b>		2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>840PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>216-22-7615</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>
	8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>6344 Davis Road</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Building Service Manager</b>		16b. Kind of Business/Industry <b>Montgomery County Board of Education</b>
	17. Father's Name (First, Middle, Last) <b>Basil K. Dorsey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mandella Costley</b>		
	19. Informant's Name/Relationship (Type, Print) <b>Barbara A. Dorsey Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>513 Division Street Harrisburg, PA 17110</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Church Cemetery</b>		20c. Location - City or Town, State <b>4/26 Taylorsville, MD</b>
	21. Signature of Funeral Service Licensee <b>James B. Group</b>		22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>BRANSFEM Cerebrovascular Accident</b> Due to (or as a consequence of): b. <b>ASPIRATION PNEUMONIA</b> Due to (or as a consequence of): c. <b>HYPERTENSION</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 week</b> <b>1 week</b> <b>5 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier <b>Dan H. Schreiberfer MD</b>		29c. License number <b>028221</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAN H. SCHREIBERFER, MD 200 MEMORIAL AVENUE WESTMINSTER MARYLAND</b>				
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>John Andrew Randall</b>			<b>21157</b>

Baltimore, Maryland 21215-0020

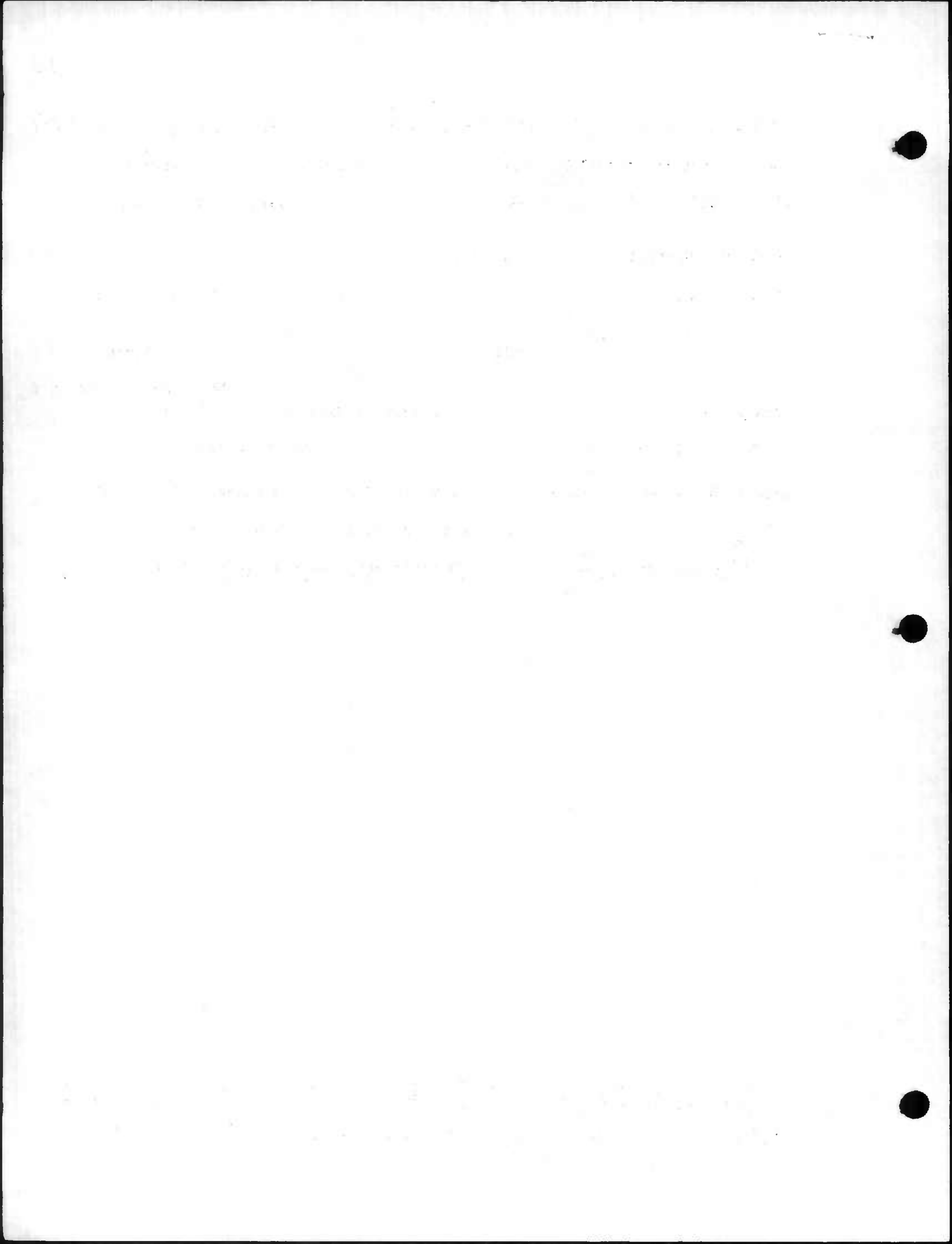
Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 12080

## Reg. No.

DHHM 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12081

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VINCENT ALLEN DRISGILL				2. Date of Death Month Day Year APRIL 18 1996		3. Time of Death 10:00 AM		
	4a. Facility Name (If not institution, give street and number) 7753 NOTLEY ROAD				4b. City, Town, or Location of Death PASADENA		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 212-07-9032	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 30 1911	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location PASADENA			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 7753 NOTLEY ROAD			10f. Zip Code 21122		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry AUTOMOBILES				
	17. Father's Name (First, Middle, Last) THOMAS DRISGILL			18. Mother's Name (First, Middle, Maiden Surname) MARGARET BORNMAN					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DOROTHY M. DRISGILL - SPOUSE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7753 NOTLEY ROAD, PASADENA, MD 21122					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date 4-22-96		20c. Location - City or Town, State BALTIMORE, MD		
	21. Signature of Funeral Service Licensee HEAVY STALLINGS, JR.			22. Name and Address of Facility STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Respiratory Failure - Acute &amp; Chronic</u> 2 wks Due to (or as a consequence of):  b. <u>Advanced Emphysema + Interstitial cardiomyopathy</u> 3 years Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number H 17744		29d. Date signed (Month, Day, Year) 4/18/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. SCHWARTZ, M.D., 300 HOSPITAL DRIVE, GLEN BURNIE, MD 21061									
31. Date filed (Month, Day, Year) APR 25 1996			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12082

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sol ELLenson</b>				2. Date of Death Month <b>April</b> Day <b>20</b> Year <b>1996</b>				3. Time of Death <b>2044</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-07-9561</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth Month <b>Feb</b> Day <b>26</b> Year <b>1912</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent				10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10a. Street and Number <b>6300 RED CEDAR PLACE, APT. 104</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT</b>		16b. Kind of Business/Industry <b>FOOD</b>			
	17. Father's Name (First, Middle, Last) <b>JACOB ELLENSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH DALEVITZ</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. ANNETTE ELLENSON (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6300 RED CEDAR PLACE, APT. 104 BALTIMORE, MD 21209</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEB SHALOM MEMORIAL PARK - 4-22-1996- REISTERSTOWN, MD</b>		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee <b>Scott M. Cutler</b>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>METASTATIC PROSTATE CANCER</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>several years</b>					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Allen Friedman For Marshall A. Levine</b>				29c. License number <b>D24888</b>		
29d. Data signed (Month, Day, Year) <b>04/20/96</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Allen Friedman</b>						
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <b>Handell</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

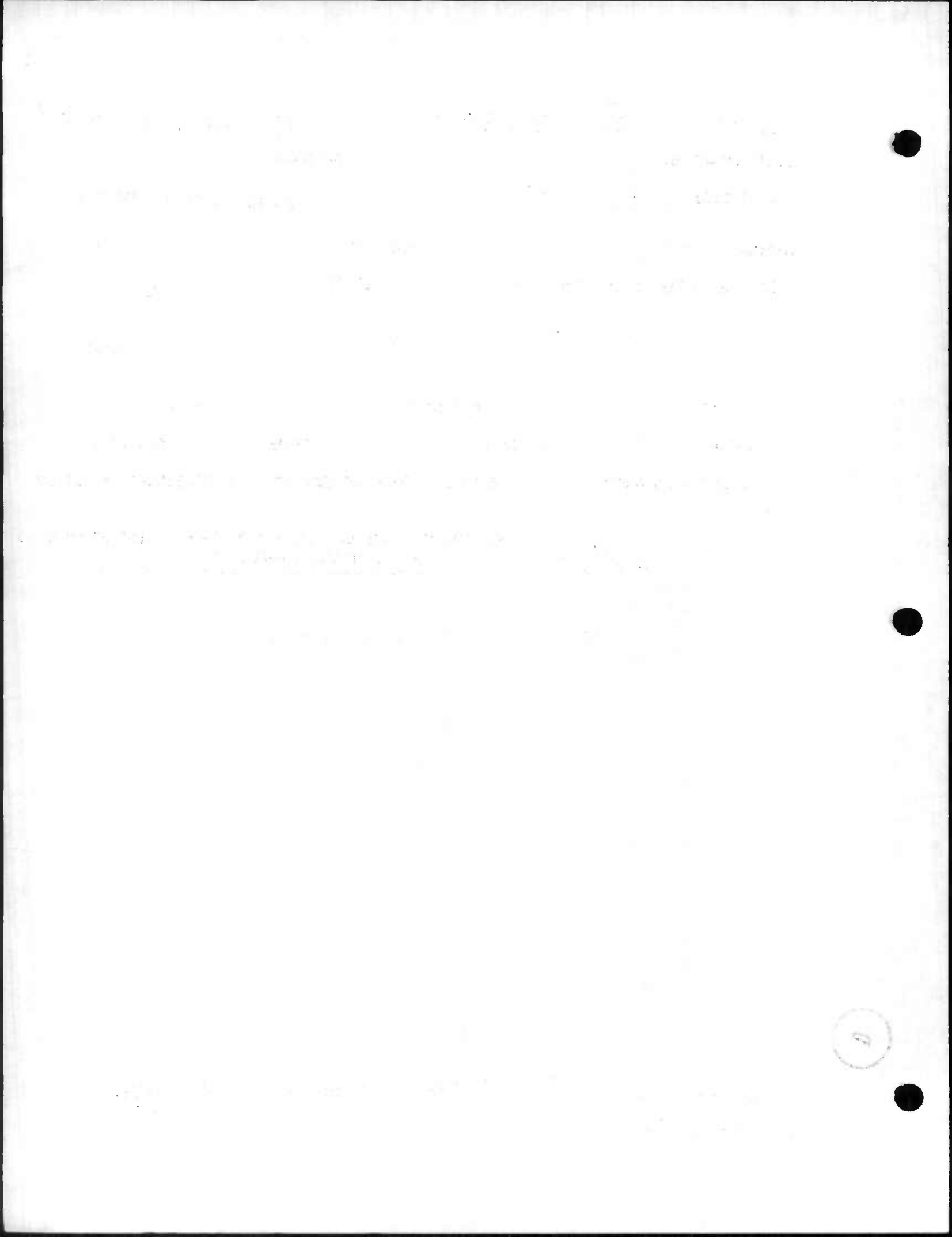
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and only properly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12083

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVIA EBBERTS				2. Date of Death Month Day Year APRIL 23, 1996		3. Time of Death 5:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 102 CRAIN HWY., APT. 882				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 217-09-6550	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 5, 1908		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 102 CRAIN HWY., APT. 882				10f. Zip Code 21061		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SILK SCREENER			16b. Kind of Business/Industry WESTINGHOUSE	
	17. Father's Name (First, Middle, Last) AARON BROWN				18. Mother's Name (First, Middle, Maiden Surname) MARY WENGERT			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) EVELYN L. SHARP / FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1179 DELMONT RD., SEVERN, MARYLAND 21144			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK., APR. 26, 1996		Date APR. 26, 1996		20c. Location - City or Town, State GLEN BURNIE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <p>a. Hypoglycemia</p> <p>b. Hyperinsulinemia</p> <p>c. Cardiac arrhythmias</p> <p>d. Cerebrovascular accident</p>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 37250		29d. Date signed (Month, Day, Year) APRIL 24, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHWANI BASSI, M.D., 206 CRAIN HWY., S.W., GLEN BURNIE, MD 21061								
State Registrar	31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12084

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Constance Falls</i>				2. Date of Death Month <i>April</i> Day <i>4</i> , Year <i>1996</i>		3. Time of Death <i>4:45 p.m.</i>		
	4a. Facility Name (If not institution, give street and number) <i>3025 Virginia Avenue</i>				4b. City, Town, or Location of Death <i>Halethorpe</i>		4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>216-16-6790</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>72</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jan. 29, 1924</i>		
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Hanover</i>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>1392 Hanover Road</i>		10f. Zip Code <i>21076</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Legal Secretary</i>		16b. Kind of Business/Industry <i>Law Firm</i>		17. Father's Name (First, Middle, Last) <i>Claude W. Sacker</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Josephine Pruks</i>	
19a. Intendant's Name/Relationship (Type, Print) <i>Linda Gutkoska/Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3025 Virginia Avenue-Baltimore, Maryland 21227</i>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Joseph B. Van Sant</i>		22. Name and Address of Facility <i>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Brain Metastases</i> <i>Endometrial Cancer</i>		Approximate Interval Between Onset and Death <i>2 mo</i>			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Wm C Waterfield MD</i>		29c. License number <i>024356 MD</i>		29d. Date signed (Month, Day, Year) <i>April 10, 1996</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Wm C Waterfield MD</i>		31. Date filed (Month, Day, Year) <i>APR 25 1996</i>		32. Registrar's Signature <i>J. Davidson-Randall</i>		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>St Agnes Hospital 900 Canton Ave Balt Md 21229</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12085**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clayborne Fairfax</b>				2. Date of Death Month <b>April</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>6:50 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-07-2724</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 29, 1920</b>		9. Birthplace (State or Foreign Country) <b>unknown</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rosedale</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2000 Odell Avenue</b>			10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>unknown</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>		
17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary Crippens/Sister-in-Law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		20d. Date		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adenocarcinoma of the gallbladder</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Humberto A. Rossi</b>		29c. License number <b>96022</b>		29d. Date signed (Month, Day, Year) <b>April 22, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Humberto A. Rossi</b>				<b>Johns Hopkins Bayview Medical Center 4940 Eastern Ave. Baltimore, MD 21224</b>				
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12086

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald R. Furbee				2. Date of Death Month Day Year April 24, 1996				3. Time of Death 10:04 AM	
	4a. Facility Name (If not institution, give street and number) 2821 Carroll Street				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-10-6849		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 8, 1922		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 2821 Carroll Street		10f. Zip Code 21230		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) inspector		16b. Kind of Business/Industry Westinghouse			
	17. Father's Name (First, Middle, Last) Oscar Burl Furbee				18. Mother's Name (First, Middle, Maiden Surname) Lillian Tschappott					
	19a. Informant's Name/Relationship (Type, Print) Anna Furbee, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2821 Carroll Street Baltimore, Maryland 21230					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial		20c. Date 4/26/96		20d. Location - City or Town, State Dorsey, Maryland			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 15 mins.					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus with neuropathy Severe chronic obstructive lung disease Hypothyroidism				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Kamal K. Darg 29c. License number D18362				29d. Date signed (Month, Day, Year) April 24, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kamal K. Darg, M.D., 3550 Kens Ave Balto MD 21229				31. Date filed (Month, Day, Year) APR 25 1996						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12087

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Beulah Maythorn Flanagan</b>				2. Date of Death Month Day Year <b>April 23, 1996</b>		3. Time of Death <b>4:07am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220-03-1904</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 5, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10e. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>1505 Shawan Road</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Black &amp; Decker</b>			
	17. Father's Name (First, Middle, Last) <b>Stephen Josiah Steffey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Effie Margaret Litz</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>John W. Flanagan</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>386 Old Mill Road, Conowingo, MD 21918</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Grdns. April</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>			
	21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>		22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerosis Heart Disease</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPITAL</b>	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D19164</b>		29d. Date signed (Month, Day, Year) <b>4/25/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Alan J. Baldanza, M.D. 10629 York Rd., Cockeysville, MD 21030</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12088

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Ida FALLIN</b>				2. Date of Death Month <b>April</b> Day <b>22</b> , Year <b>1996</b>				3. Time of Death <b>4:30 pm.</b>	
4a. Facility Name (If not institution, give street and number) <b>Greenspring Nursing &amp; Rehab Center</b>				4b. City, Town, or Location of Death <b>Baltimore, MD</b>				4c. County of Death <b>N/A</b>	
5. Social Security Number <b>214-86-7017</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 3, 1903</b>		9. Birthplace (State or Foreign Country) <b>Kingston, Jamaica</b>	
Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4600 Park Heights Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U S A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dress Maker</b>			16b. Kind of Business/Industry <b>Tailor</b>		
17. Father's Name (First, Middle, Last) <b>John Curry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mammie Curry</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joy Patterson Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3704 Park Heights Baltimore, Md 21215</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Zion Cemetery</b>		Date <b>4/25/96</b>		20c. Location - City or Town, State <b>Lansdown, Md</b>			
21. Signature of Funeral Service Licensee <b>Gabrielle Cook</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md</b>					

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death <b>4 years</b>
Immediate Cause (Final disease or condition resulting in death) a. <b>Alzheimer Disease</b> Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>arteriosclerotic Cardiovascular Disease</b> <b>Peripheral Vascular Disease: rt above knee amputations</b> <b>Sacral Discolitis</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Manuel Kevin MD</b>		29c. License number <b>D 05622</b>	
29d. Date signed (Month, Day, Year) <b>3/24/96</b>					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MANUEL KEVIN MD 6101 PK HTS AVE. BALTO. MD 21215</b>	
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>	32. Registrar's Signature <b>U. A. Davidson</b>

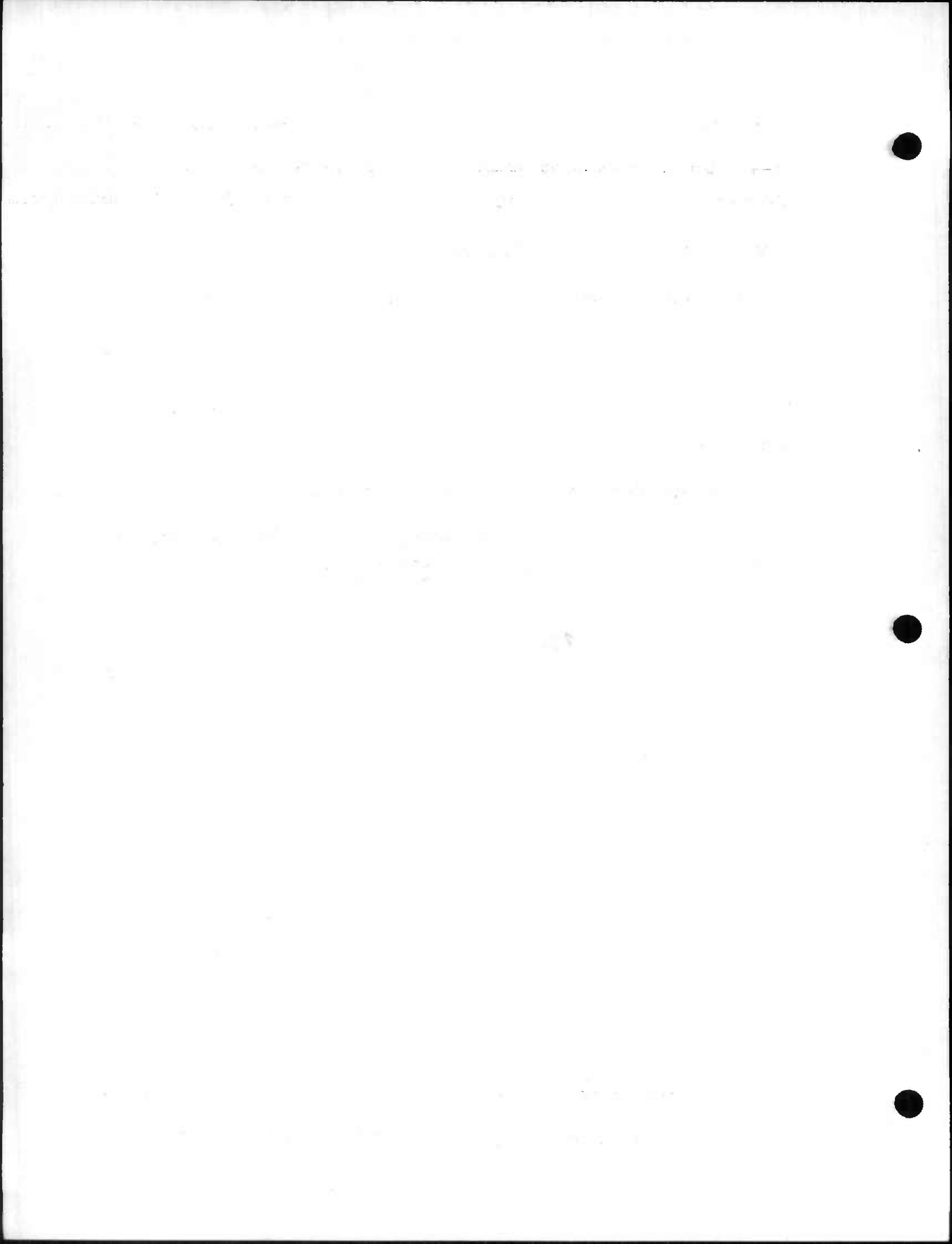
State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2



asp

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State of Maryland / Department of Health and Mental Hygiene 96 12089

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DARNELL FELDER</b>				2. Date of Death <b>APRIL 22 1996</b>		3. Time of Death <b>2:32 A</b>		
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL ER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>217-48-4186</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 5, 1952</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b>				10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1021 Monroe St.</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto Mechanic</b>		16b. Kind of Business/Industry <b>Garage</b>				
	17. Father's Name (First, Middle, Last) <b>Ernest Felder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beatrice Harris</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ms. Shanta Felder</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2111 Tucker Lane Apt. 8 Balto. Md. 21207</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Location - City or Town, State <b>4/29/96 Lansdowne, Md.</b>				
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ 1222 W. North Ave F/H</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acquired immune deficiency syndrome</b> Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Darnell R Felder 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and all pages.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12090

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <i>Sylvan Golaner</i>				2. Date of Death Month <i>April</i> Day <i>15</i> Year <i>1996</i>		3. Time of Death <i>6:15 P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Union Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>214-01-5221 A</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>90</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 3, 1905</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedant							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>3208 Kentucky Avenue</i>				10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U. S. A.</i>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>6th Grade</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Salesman</i>		16b. Kind of Business/Industry <i>Ice Company</i>			
	17. Father's Name (First, Middle, Last) <i>Jacob Golaner</i>				18. Mother's Name (First, Middle, Maiden Summa) <i>Margaret Miller</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>John J. Wise (Nephew)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3607 E. Fayette St., Baltimore, Maryland 21224</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Most Holy Redeemer</i>		Data <i>4/18/96</i>	20c. Location - City or Town, State <i>Baltimore, Maryland</i>		
	21. Signature of Funeral Service Licensee <i>Robert J. Soback Jr.</i>				22. Name and Address of Facility <i>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Angina - Ischemic Heart Disease</i> Due to (or as a consequence of):  b. <i>Arterial Hypertension</i> Due to (or as a consequence of):  c. <i>SIPAT</i> Due to (or as a consequence of):  d. <i>B/L Reg. aneurysm</i>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>4/16/96</i>		28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Marguerite J. Moran MD</i>		29c. License number <i>D08093</i>		29d. Date signed (Month, Day, Year) <i>4-16-96</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marguerite Moran M.D., Brehms Lane Med. Center, 3300 Brehms Lane, Balto., Md.</i>								
31. Date filed (Month, Day, Year) <i>APR 25 1996</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12091

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHRYN ALICE GELSLEICHTER				2. Date of Death Month Day Year April 15, 1996		3. Time of Death 11:00 pm	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 578-30-2028		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) June 21, 1906	
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number Furnace Street Extended		10f. Zip Code 21502		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria		16b. Kind of Business/Industry Montgomery County Public Schools				
17. Father's Name (First, Middle, Last) John Snyder				18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Robbins				
19a. Informant's Name/Relationship (Type, Print) Thelma A. Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14605 Myer Terrace Rockville, MD 20853				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery		20c. Location - City or Town, State 4/19/96 Burtonsville, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Grove Funeral Home P.O. Box 368 Hancock, MD 21750				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced Coronary Artery Disease Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. Due to (or as a consequence of): d. Depression Approximate interval Between Onset and Death > 20 years 1 week > 5 years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 23371		29d. Date signed (Month, Day, Year) April 17, 1996		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502								
31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Carroll Francis Graham</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 23 1996</b>				3. TIME OF DEATH <b>11:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214 82 0373</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 5, 1921</b>		8. BIRTHPLACE (State or Foreign) <b>CUMBERLAND, MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>909 ANDOVER ROAD</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk.</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED</b>				16b. KIND OF BUSINESS/INDUSTRY <b>never worked</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unk.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIE PINKEY GRAHAM</b>					
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY LEDFORD SADDLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909 ANDOVER ROAD, BALTIMORE, md 21218</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL PARK 4-26</b>		DATE <b>4-26</b>		20c. LOCATION — City or Town, State <b>DUNDALK MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>wm. c. march fh.-1101 E. NORTH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. septic shock</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. metastatic papillary carcinoma of the thyroid</b>								Approximate Interval Between Onset and Death <b>3 Days</b> <b>3 Days</b> <b>3 Days</b> <b>4 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypokalemia Dilantin toxicity</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>MD</b>		29c. LICENSE NUMBER <b>AT 2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/23/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Hassan A. Nasser Union Memorial Hospital 201 E. Univ. Parkway Baltimore, MD 21218</b>									
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12093

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Deford Garrett</b>				2. Date of Death Month <b>April</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>5:22 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston, MD</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>215-09-8425</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 22, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore, City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>6511 Glenoak Ave.</b>		10f. Zip Code <b>21214</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Buyer</b>				16b. Kind of Business/Industry <b>Department Store</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Bowling</b>				19. Informant's Name/Relationship (Type, Print) <b>Mrs. Barbara Foard Neice</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2407 Bond Road - Parkton, Md. 21120</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Ronald C. Schuler</b>				22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Baltimore, Maryland 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac Arrest 20 to 40 to 50 to 60 to 70 to 80 to 90 to 100 to 110 to 120 to 130 to 140 to 150 to 160 to 170 to 180 to 190 to 200 to 210 to 220 to 230 to 240 to 250 to 260 to 270 to 280 to 290 to 300 to 310 to 320 to 330 to 340 to 350 to 360 to 370 to 380 to 390 to 400 to 410 to 420 to 430 to 440 to 450 to 460 to 470 to 480 to 490 to 500 to 510 to 520 to 530 to 540 to 550 to 560 to 570 to 580 to 590 to 600 to 610 to 620 to 630 to 640 to 650 to 660 to 670 to 680 to 690 to 700 to 710 to 720 to 730 to 740 to 750 to 760 to 770 to 780 to 790 to 800 to 810 to 820 to 830 to 840 to 850 to 860 to 870 to 880 to 890 to 900 to 910 to 920 to 930 to 940 to 950 to 960 to 970 to 980 to 990 to 1000 to 1010 to 1020 to 1030 to 1040 to 1050 to 1060 to 1070 to 1080 to 1090 to 1100 to 1110 to 1120 to 1130 to 1140 to 1150 to 1160 to 1170 to 1180 to 1190 to 1200 to 1210 to 1220 to 1230 to 1240 to 1250 to 1260 to 1270 to 1280 to 1290 to 1300 to 1310 to 1320 to 1330 to 1340 to 1350 to 1360 to 1370 to 1380 to 1390 to 1400 to 1410 to 1420 to 1430 to 1440 to 1450 to 1460 to 1470 to 1480 to 1490 to 1500 to 1510 to 1520 to 1530 to 1540 to 1550 to 1560 to 1570 to 1580 to 1590 to 1600 to 1610 to 1620 to 1630 to 1640 to 1650 to 1660 to 1670 to 1680 to 1690 to 1700 to 1710 to 1720 to 1730 to 1740 to 1750 to 1760 to 1770 to 1780 to 1790 to 1800 to 1810 to 1820 to 1830 to 1840 to 1850 to 1860 to 1870 to 1880 to 1890 to 1900 to 1910 to 1920 to 1930 to 1940 to 1950 to 1960 to 1970 to 1980 to 1990 to 2000 to 2010 to 2020 to 2030 to 2040 to 2050 to 2060 to 2070 to 2080 to 2090 to 2100 to 2110 to 2120 to 2130 to 2140 to 2150 to 2160 to 2170 to 2180 to 2190 to 2200 to 2210 to 2220 to 2230 to 2240 to 2250 to 2260 to 2270 to 2280 to 2290 to 2300 to 2310 to 2320 to 2330 to 2340 to 2350 to 2360 to 2370 to 2380 to 2390 to 2400 to 2410 to 2420 to 2430 to 2440 to 2450 to 2460 to 2470 to 2480 to 2490 to 2500 to 2510 to 2520 to 2530 to 2540 to 2550 to 2560 to 2570 to 2580 to 2590 to 2600 to 2610 to 2620 to 2630 to 2640 to 2650 to 2660 to 2670 to 2680 to 2690 to 2700 to 2710 to 2720 to 2730 to 2740 to 2750 to 2760 to 2770 to 2780 to 2790 to 2800 to 2810 to 2820 to 2830 to 2840 to 2850 to 2860 to 2870 to 2880 to 2890 to 2900 to 2910 to 2920 to 2930 to 2940 to 2950 to 2960 to 2970 to 2980 to 2990 to 3000 to 3010 to 3020 to 3030 to 3040 to 3050 to 3060 to 3070 to 3080 to 3090 to 3100 to 3110 to 3120 to 3130 to 3140 to 3150 to 3160 to 3170 to 3180 to 3190 to 3200 to 3210 to 3220 to 3230 to 3240 to 3250 to 3260 to 3270 to 3280 to 3290 to 3300 to 3310 to 3320 to 3330 to 3340 to 3350 to 3360 to 3370 to 3380 to 3390 to 3400 to 3410 to 3420 to 3430 to 3440 to 3450 to 3460 to 3470 to 3480 to 3490 to 3500 to 3510 to 3520 to 3530 to 3540 to 3550 to 3560 to 3570 to 3580 to 3590 to 3600 to 3610 to 3620 to 3630 to 3640 to 3650 to 3660 to 3670 to 3680 to 3690 to 3700 to 3710 to 3720 to 3730 to 3740 to 3750 to 3760 to 3770 to 3780 to 3790 to 3800 to 3810 to 3820 to 3830 to 3840 to 3850 to 3860 to 3870 to 3880 to 3890 to 3900 to 3910 to 3920 to 3930 to 3940 to 3950 to 3960 to 3970 to 3980 to 3990 to 4000 to 4010 to 4020 to 4030 to 4040 to 4050 to 4060 to 4070 to 4080 to 4090 to 4100 to 4110 to 4120 to 4130 to 4140 to 4150 to 4160 to 4170 to 4180 to 4190 to 4200 to 4210 to 4220 to 4230 to 4240 to 4250 to 4260 to 4270 to 4280 to 4290 to 4300 to 4310 to 4320 to 4330 to 4340 to 4350 to 4360 to 4370 to 4380 to 4390 to 4400 to 4410 to 4420 to 4430 to 4440 to 4450 to 4460 to 4470 to 4480 to 4490 to 4500 to 4510 to 4520 to 4530 to 4540 to 4550 to 4560 to 4570 to 4580 to 4590 to 4600 to 4610 to 4620 to 4630 to 4640 to 4650 to 4660 to 4670 to 4680 to 4690 to 4700 to 4710 to 4720 to 4730 to 4740 to 4750 to 4760 to 4770 to 4780 to 4790 to 4800 to 4810 to 4820 to 4830 to 4840 to 4850 to 4860 to 4870 to 4880 to 4890 to 4900 to 4910 to 4920 to 4930 to 4940 to 4950 to 4960 to 4970 to 4980 to 4990 to 5000 to 5010 to 5020 to 5030 to 5040 to 5050 to 5060 to 5070 to 5080 to 5090 to 5100 to 5110 to 5120 to 5130 to 5140 to 5150 to 5160 to 5170 to 5180 to 5190 to 5200 to 5210 to 5220 to 5230 to 5240 to 5250 to 5260 to 5270 to 5280 to 5290 to 5300 to 5310 to 5320 to 5330 to 5340 to 5350 to 5360 to 5370 to 5380 to 5390 to 5400 to 5410 to 5420 to 5430 to 5440 to 5450 to 5460 to 5470 to 5480 to 5490 to 5500 to 5510 to 5520 to 5530 to 5540 to 5550 to 5560 to 5570 to 5580 to 5590 to 5600 to 5610 to 5620 to 5630 to 5640 to 5650 to 5660 to 5670 to 5680 to 5690 to 5700 to 5710 to 5720 to 5730 to 5740 to 5750 to 5760 to 5770 to 5780 to 5790 to 5800 to 5810 to 5820 to 5830 to 5840 to 5850 to 5860 to 5870 to 5880 to 5890 to 5900 to 5910 to 5920 to 5930 to 5940 to 5950 to 5960 to 5970 to 5980 to 5990 to 6000 to 6010 to 6020 to 6030 to 6040 to 6050 to 6060 to 6070 to 6080 to 6090 to 6100 to 6110 to 6120 to 6130 to 6140 to 6150 to 6160 to 6170 to 6180 to 6190 to 6200 to 6210 to 6220 to 6230 to 6240 to 6250 to 6260 to 6270 to 6280 to 6290 to 6300 to 6310 to 6320 to 6330 to 6340 to 6350 to 6360 to 6370 to 6380 to 6390 to 6400 to 6410 to 6420 to 6430 to 6440 to 6450 to 6460 to 6470 to 6480 to 6490 to 6500 to 6510 to 6520 to 6530 to 6540 to 6550 to 6560 to 6570 to 6580 to 6590 to 6600 to 6610 to 6620 to 6630 to 6640 to 6650 to 6660 to 6670 to 6680 to 6690 to 6700 to 6710 to 6720 to 6730 to 6740 to 6750 to 6760 to 6770 to 6780 to 6790 to 6800 to 6810 to 6820 to 6830 to 6840 to 6850 to 6860 to 6870 to 6880 to 6890 to 6900 to 6910 to 6920 to 6930 to 6940 to 6950 to 6960 to 6970 to 6980 to 6990 to 7000 to 7010 to 7020 to 7030 to 7040 to 7050 to 7060 to 7070 to 7080 to 7090 to 7100 to 7110 to 7120 to 7130 to 7140 to 7150 to 7160 to 7170 to 7180 to 7190 to 7200 to 7210 to 7220 to 7230 to 7240 to 7250 to 7260 to 7270 to 7280 to 7290 to 7300 to 7310 to 7320 to 7330 to 7340 to 7350 to 7360 to 7370 to 7380 to 7390 to 7400 to 7410 to 7420 to 7430 to 7440 to 7450 to 7460 to 7470 to 7480 to 7490 to 7500 to 7510 to 7520 to 7530 to 7540 to 7550 to 7560 to 7570 to 7580 to 7590 to 7600 to 7610 to 7620 to 7630 to 7640 to 7650 to 7660 to 7670 to 7680 to 7690 to 7700 to 7710 to 7720 to 7730 to 7740 to 7750 to 7760 to 7770 to 7780 to 7790 to 7800 to 7810 to 7820 to 7830 to 7840 to 7850 to 7860 to 7870 to 7880 to 7890 to 7900 to 7910 to 7920 to 7930 to 7940 to 7950 to 7960 to 7970 to 7980 to 7990 to 8000 to 8010 to 8020 to 8030 to 8040 to 8050 to 8060 to 8070 to 8080 to 8090 to 8100 to 8110 to 8120 to 8130 to 8140 to 8150 to 8160 to 8170 to 8180 to 8190 to 8200 to 8210 to 8220 to 8230 to 8240 to 8250 to 8260 to 8270 to 8280 to 8290 to 8300 to 8310 to 8320 to 8330 to 8340 to 8350 to 8360 to 8370 to 8380 to 8390 to 8400 to 8410 to 8420 to 8430 to 8440 to 8450 to 8460 to 8470 to 8480 to 8490 to 8500 to 8510 to 8520 to 8530 to 8540 to 8550 to 8560 to 8570 to 8580 to 8590 to 8600 to 8610 to 8620 to 8630 to 8640 to 8650 to 8660 to 8670 to 8680 to 8690 to 8700 to 8710 to 8720 to 8730 to 8740 to 8750 to 8760 to 8770 to 8780 to 8790 to 8800 to 8810 to 8820 to 8830 to 8840 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State of Maryland / Department of Health and Mental Hygiene

96 12094

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent Chris Galluzzo					2. Date of Death Month Day Year APRIL 22 1996		3. Time of Death 7:30 PM	
	4a. Facility Name (If not institution, give street and number) Windsor Ridge Nursing & Rehab. Center					4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 072-10-2285		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. If Under 1 Year Months Days	9. If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) SEPT 30, 1908		9. Birthplace (State or Foreign Country) Argentina
	Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8548 Oakleigh Road					10f. Zip Code 21234		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor			16b. Kind of Business/Industry Construction Industry		
17. Father's Name (First, Middle, Last) Daniel Galluzzo					18. Mother's Name (First, Middle, Maiden Surname) Elise Conte				
19a. Informant's Name/Relationship (Type, Print) Angela Galluzzo/Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8548 Oakleigh Rd. Baltimore, MD 21234				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 4/23/96			20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Dawn F. McDonald					22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier Raymond Miller MD		29c. License number D47683		29d. Date signed (Month, Day, Year) 4/23/96
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Raymond Miller 7220 Park Heights Ave., Baltimore, MD 21208									
31. Date filed (Month, Day, Year) APR 25 1996					32. Registrar's Signature J. Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JA

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12095

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARILYN GELBLUM</b>		2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>2:15am</b>
	4a. Facility Name (If not institution, give street and number) <b>5 POMONA NORTH, APT. 11</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>218-26-8533</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 26, 1930</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>5 POMONA NORTH, APT. 11</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WRITER</b>		16b. Kind of Business/Industry <b>SOCIAL SECURITY</b>	
17. Father's Name (First, Middle, Last) <b>AARON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SOPHIA HORNSTEIN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MRS. SALLY WOLF (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4924 VALLEY PINE DRIVE FREDERICK, MD 21703</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MIKRO KODESH BETH ISRAEL</b>		20c. Location - City or Town, State <b>- 4-23-1996- BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Arrest</b> Due to (or as a consequence of): b. <b>Pancreatic Carcinoma</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 23985</b>		29d. Date signed (Month, Day, Year) <b>4/22/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. JOYCE GROSS 20 CROSSROADS DRIVE OWINGS MILLS, MD 21117</b>					
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 12096

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHRISTINA MARGARET GEPII				2. Date of Death Month Day Year APRIL 22 1996				3. Time of Death 10:31 PM													
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL													
Funeral Director	5. Social Security Number 218-22-6725		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 27 1910		9. Birthplace (State or Foreign Country) MARYLAND													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 8129 SOLLEY ROAD				10f. Zip Code 21122		10g. Citizen of What Country? USA															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry HOUSEHOLD														
	17. Father's Name (First, Middle, Last) SOULE				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN																	
	19a. Informant's Name/Relationship (Type, Print) LAWRENCE S. GEPII, SR. - SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8129 SOLLEY ROAD, PASADENA, MD 21122																	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		Date 4/26/96		20c. Location - City or Town, State GLEN BURNIE, MD															
	21. Signature of Funeral Service Licensee HILARY L. STALLINGS, JR.				22. Name and Address of Facility STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>CORONARY ARTERY DISEASE</td> <td>10 YEARS</td> </tr> <tr> <td>b.</td> <td>DIABETES</td> <td>15 YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	CORONARY ARTERY DISEASE	10 YEARS	b.	DIABETES	15 YEARS	c.			d.	
Immediate Cause (Final disease or condition resulting in death)	a.	CORONARY ARTERY DISEASE	10 YEARS																			
	b.	DIABETES	15 YEARS																			
	c.																					
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																						
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier 29c. License number MD 26664 29d. Date signed (Month, Day, Year) 4/23/96																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL YOUNG-HYMAN, M.D., 1600 CRAIN HIGHWAY SOUTH, GLEN BURNIE, MD 21061																						
31. Date filed (Month, Day, Year) APR 25 1996 32. Registrar's Signature Julia Davidson Randall																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12097

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Louella B. McGrogan</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>20</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>11:00 A</u> M	
4. SOCIAL SECURITY NUMBER <u>203-14-6633</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>79</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 22, 1916</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Sykesville ElderCare</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Sykesville</u>	
9c. COUNTY OF DEATH <u>Carroll</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Carroll</u>	
10c. CITY, TOWN OR LOCATION <u>Sykesville</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>7309 Second Ave.</u>	
10f. ZIP CODE <u>21784</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>8th Grade</u> College (1-4 or 5+) <u>Homemaker</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <u>Homemaker</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Finley I. Holler</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Agnes Rock</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Phyllis M. Jones (Daughter)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4350 Old Washington Rd. Sykesville, MD 21784</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Greenmount Cemetery 4-24 Philadelphia, PA</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>John K. Ayers</u>				22. NAME AND ADDRESS OF FACILITY <u>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Dementia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>3 months</u> <u>9 YRS.</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atherosclerotic Cardiovascular Disease</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <u>M</u> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>John K. Ayers</u> 29c. LICENSE NUMBER <u>114753</u> 29d. DATE SIGNED (Month, Day, Year) <u>4/20/96</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>8620 Liberty Pike, P.O. Box 21123, Randallstown, MD 21123</u>							
31. DATE FILED (Month, Day, Year) <u>APR 25 1996</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12098

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Carl Holmes, Jr

2. Date of Death

APRIL 13 1996

3. Time of Death

8:39 pm

4a. Facility Name (If not institution, give street and number)

University of Maryland NICU

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

04/08/96

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7208 Donnell Court

10f. Zip Code

20747

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Carl Holmes, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Lesley Holmes

19a. Informant's Name/Relationship (Type, Print)

Carl and Lesley Homes/Parents

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7208 Donnell Street-Forrestville, Maryland 20747

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street

Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Extreme Prematurity  
Due to (or as a consequence of):b. Respiratory Distress Syndrome  
Due to (or as a consequence of):c. Bleeding Diathesis  
Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Debra L. Birenbaum, M.D.

29c. License number

D43775

29d. Date signed (Month, Day, Year)

April 13, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Debra L. Birenbaum, MD

31. Date filed (Month, Day, Year)

... 25 1996

32. Registrar's Signature

Judson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12099

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BESSIE MASON HOLMES</b>						2. Date of Death Month <b>APRIL</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>10:35 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>						4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>UNKNOWN</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 11, 1911 U. Carolina</b>		9. Birthplace (State or Foreign Country)		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2841 W. NORTH AVENUE</b>				10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>JOHN MASON</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA COOK</b>					
19a. Informant's Name/Relationship (Type, Print) <b>VANESSA GRANT, Grand Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6824 Brompton Road Baltimore MD 21207</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUS MEMORIAL PARK</b>			20c. Date <b>4-25-96</b>		20d. Location - City or Town, State <b>ARBUS, Maryland</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>CHATMAN - AORN Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21211</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Michael Rothkin MD</b>						29c. License number <b>D43481</b>		29d. Date signed (Month, Day, Year) <b>APRIL 19, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ROTHKIN 5101 BROADVIEW OLD COURT ROAD RANDALLSTOWN, MD 21133</b>											
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12100

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lillian Rebecca Hax</i>				2. Date of Death Month <i>April</i> Day <i>22</i> Year <i>1996</i>		3. Time of Death <i>6:55 P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>MedBridge Nursing Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>240-16-2051</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>78</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 11, 1917</i>	
	9. Birthplace (State or Foreign Country) <i>N. Carolina</i>		10a. State <i>Maryland</i>		10b. County <i>Harford</i>		10c. City, Town or Location <i>Fallston</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>1105 Peach Tree Road</i>		10f. Zip Code <i>21047</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Unknown</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>			
	17. Father's Name (First, Middle, Last) <i>Albert Cicero Cline</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Etta (surname unknown)</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Charles Hax (step-son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1105 Peach Tree Road, Fallston, MD 21047</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Baltimore Cemetery</i>		Date <i>4/25/96</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. CA CHEXIA</i> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d.</i>							
	Approximate interval between Onset and Death <i>2 months</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC OBSTRUCTIVE LUNG DISEASE</i>							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury <i>M</i>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>								
29c. License number <i>023967</i>								
29d. Date signed (Month, Day, Year) <i>4-23-96</i>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>CEPR G. GAMBOA MD 3440 BELAIR RD. BALTO MD 21213</i>								
31. Date filed (Month, Day, Year) <i>APR 25 1996</i>								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12101

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIE HUBBARD</b>						2. Date of Death Month <b>April</b> Day <b>23</b> , Year <b>1996</b>		3. Time of Death <b>3:15 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>5215 Tramore Road</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>231-36-0402</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 2, 1929</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>5215 TRAMORE ROAD, BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5215 TRAMORE ROAD</b>				10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>UNITED STATES</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ACCOUNTS PAYABLE</b>			16b. Kind of Business/Industry <b>ENGINEERING SCHOOL</b>			
17. Father's Name (First, Middle, Last) <b>KENNY ECHOLS</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>GENNEVA <del>DODSON</del> Dodson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SUSAN G. PENN</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5215 TRAMORE ROAD MD, BALTIMORE, 21214</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAKHILL CEMETERY</b>		20c. Location - City or Town, State <b>DANVILLE, N. CAROLINA</b>		20d. Date <b>4-25</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Brain Metastases</b> Due to (or as a consequence of):</p> <p>b. <b>Small Cell Lung Cancer</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>8 month</b></p> <p><b>8 month</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred						
				28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>April 25, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David A Roseberg MD 407T 301 St Paul Place Baltimore, MD 21202</b>										
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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AM ITEMS: 23 PART I, 27, 28a-f, PER

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State of Maryland / Department of Health and Mental Hygiene

96 12102

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HUNGELMANN HUNGELMANN</b>				2. Date of Death Month Day Year <b>APRIL 20, 1996</b>		3. Time of Death <b>14:05 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>5120 BLUE MARLIN DR.</b>				4b. City, Town, or Location of Death <b>EDEN</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>220-76-7899</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 10, 1958</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Eden</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5120 Blue Marlin Drive</b>				10f. Zip Code <b>21822</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cabinet Maker</b>		16b. Kind of Business/Industry <b>Stereo Speaker Cabinet Manufacturing</b>			
	17. Father's Name (First, Middle, Last) <b>James August Hungelmann</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Ann O'Brien</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Margaret Ann Hungelmann/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>551 Lanny Court Millersville, MD 21108</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 04/22/96</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee <b>George E. MacNabb</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>PROPOXYPHENE INTOXICATION</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>FOUND: 4/20/96</b>		28b. Time of Injury at Work? <b>2:05 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>David R Fowler</b>						
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>APRIL 21, 1996</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

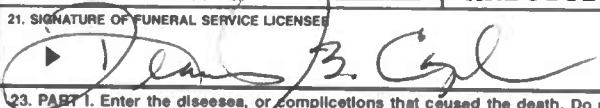

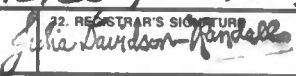
Medical Certification: To Be Completed by Physician/Medical Examiner



96 12103

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES W. HURT</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>21</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>12:45A</b>	
4. SOCIAL SECURITY NUMBER <b>213-07-1378</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 7, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1515 EAST FEDERAL STREET</b>			
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>HOT STRIP OPERATOR</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STEEL</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM H. HURT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIRGINIA MARSHALL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ODELL HURT (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1515 EAST FEDERAL ST. BALTIMORE, MD 21213</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEM PARK 4/26/96</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>CAPLE FUNERAL SERVICE</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Methicillin resistant Staph. aureus pneumonia</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. <b>Renal failure</b> b. <b>Respiratory failure</b> c. <b>Electrolyte imbalance</b> d.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D 45280</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/21/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SAJJAD MALICK 100 N. Broadway St., Baltimore, MD 21231</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12104

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSE T HELINE</b>				2. Date of Death Month <b>4</b> Day <b>24</b> Year <b>96</b>		3. Time of Death <b>1535</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>217-20-0654</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 14, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>724 DELMAR AVE.</b>		10f. Zip Code <b>21061</b>		
10g. Citizen of What Country? <b>UNITED STATES</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>JOHN MANION</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY HERCHENHAN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>WALTER F. HELINE / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>724 DELMAR AVE., GLEN BURNIE, MARYLAND 21061</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEM. PK. APR. 27, '96</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD 21061</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>cerebrovascular accident</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURES</b> <b>Crohn's disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D439177</b>		29d. Date signed (Month, Day, Year) <b>April 24th 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CYNTHIA DREYFUS, 301 HARBOR DRIVE, GLEN BURNIE MD 21061</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12105

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Oscar Frederick Haupt</b>				2. Date of Death Month <b>April</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>9:40 P.M.</b>		
	4e. Facility Name (If not institution, give street and number) <b>Augsburg Lutheran Home</b>				4b. City, Town, or Location of Death <b>Lochearn</b>		4c. County of Death <b>Baltimore County</b>		
Funeral Director	5. Social Security Number <b>214-03-1858</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1898</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State <b>Maryland</b>	10b. County <b>Baltimore County</b>	10c. City, Town or Location <b>Lochearn</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>6811 Campfield Road</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th Grade</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>			16b. Kind of Business/Industry <b>Clothing Industry</b>		
	17. Father's Name (First, Middle, Last) <b>Julius Unknown Haupt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown Unknown Unknown</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Edward Oscar Haupt/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6225 Laurelton Avenue, Baltimore, Maryland 21214</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>4/27/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>				
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebral thrombosis</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>10 minutes</b>				Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D37573</b>		29d. Date signed (Month, Day, Year) <b>4/24/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. J. Zibell MD 7220 Park Heights Ave Baltimore MD 21208</b>									
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

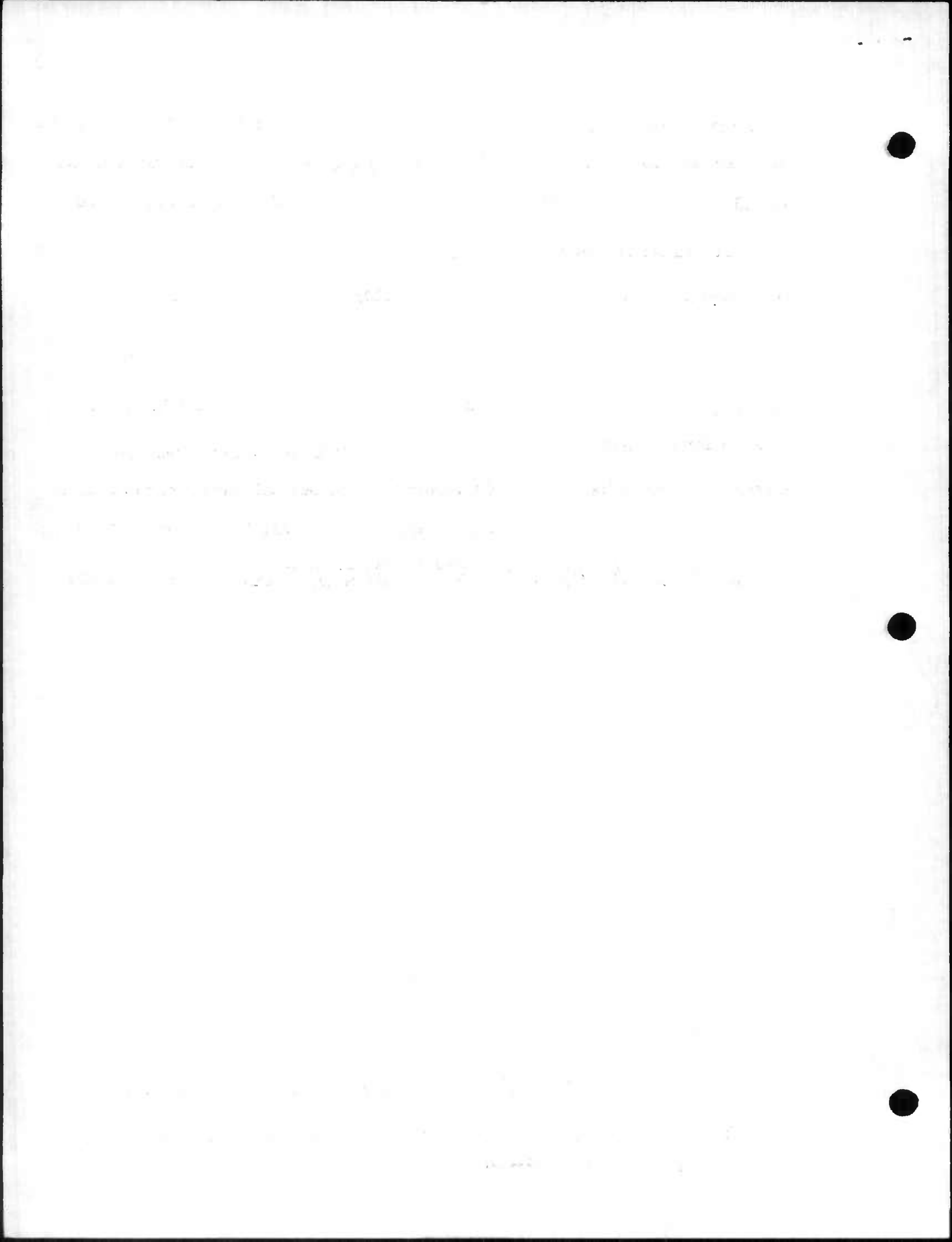
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12106

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALFRED GORDON JANNEY</b>				2. Date of Death Month Day Year <b>APRIL 23, 1996</b>		3. Time of Death <b>9:23 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-01-2323</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>	7. Age (In yrs. last birthday) <b>83</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>February 1, 1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b>	
	10e. Street and Number <b>300 International Circle</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/President</b>		16b. Kind of Business/Industry <b>Refrigeration</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John Warder Janney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Wealthy Ross</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Charles Gordon Janney Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>POBox 29 Phoenix, Maryland 21131</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		Date <b>4/25/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of): <b>b. Stroke</b> Due to (or as a consequence of): <b>c. Congestive Heart Failure</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>Days</b>  <b>Days</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>037362</b>		29d. Date signed (Month, Day, Year) <b>4/24/96</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ANTHONY SERAFIO, M.D. 1205 YORK RD 32C LUMERVILLE MD 21097</b>							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <i>[Signature]</i>					
	33. Registrar's Name <b>W. J. [Signature]</b>							



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KAMILL JONES</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>0416AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL E.R.</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>220-45-6951</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days <b>2 2</b>		8. Date of Birth (Month, Day, Year) <b>FEB. 20, 1996</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MD</b>		10b. County <b>BALTIMORE CITY</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>4922 EDMERE AVE</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>AMOS JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KIMBERLI CARROLL</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MILLER CARROLL</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4922 EDMERE AVE. BALTO., MD 21215</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEM.</b>		Date <b>4-27-96</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>270 FREDHILTON PASS CALVIN L. WILLIAMS F.S. BALTO., MD</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>HEAD AND NECK INJURY</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <b>Yes</b> 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <b>Yes</b> 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>04/22/96</b>		28b. Time of Injury <b>4:16 A M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred <b>INFANT WAS SHAKEN</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>4922 EDMERE AVE. BALTIMORE, MARYLAND</b>						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

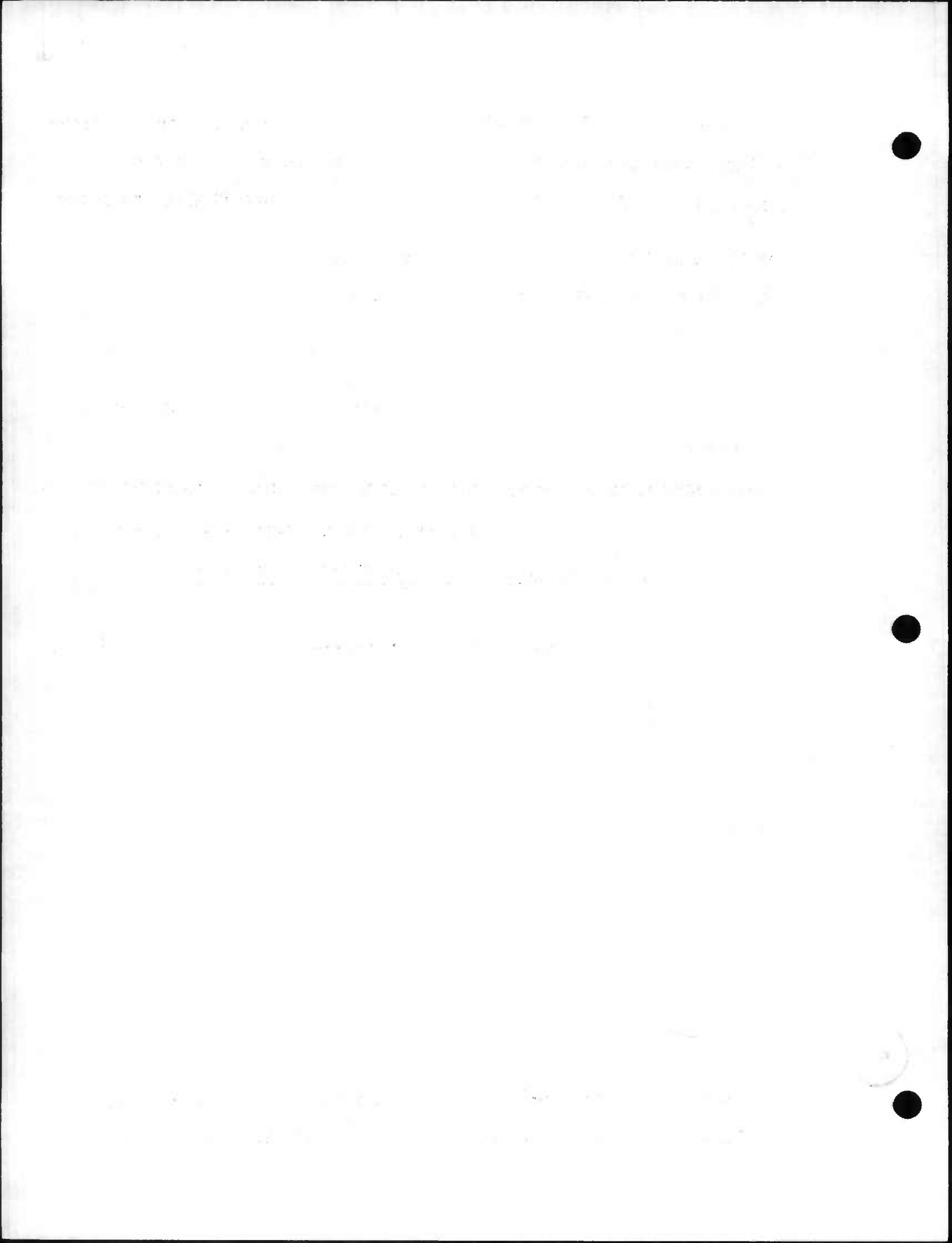
96 12108

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERBERT DAVID KAPLAN</b>				2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>11:45pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>4001 OLD COURT ROAD, APT. 401</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-07-2410A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 17, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4001 OLD COURT ROAD, APT. 401</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WHOLESALE</b>		16b. Kind of Business/Industry <b>DRUG SUNDRIES</b>			
	17. Father's Name (First, Middle, Last) <b>HERMAN KAPLAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>IDA HOLTZMAN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. ROSLYN A. KAPLAN (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4001 OLD COURT ROAD, APT. 401 BALTIMORE, MD 21208</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON-CHIZUK AMUNO</b>		Date <b>4-24-1996</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee <i>Sol Levinson</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Renal Cell Carcinoma</i></b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier <i>Sol Levinson MD</i> 29c. License number <b>D10091</b> 29d. Date signed (Month, Day, Year) <b>4/23/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7620 York Rd Towson MD 21204 Arthur A. Scarpick</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b> 32. Registrar's Signature <i>Raymond R. Riddell</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12



96 12109

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vernon Victor Kramer</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>23</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-22-1656</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 29, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>116 W. University Parkway Apt. # 1109</b>				10f. ZIP CODE <b>21210</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Commercial Artist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Publishing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jesse Kramer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Petza</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Norma Kramer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 W. University Parkway Apt. #1109 Balto., 21210</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cem. 4/27/96</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark T. Zavovna</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intra cerebral bleed</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>hypertension</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wael Samara, M.D.</b>				29c. LICENSE NUMBER <b>AT 2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/23/1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wael Samara, The Union Memorial Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12110

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Grace Kahmer</u>				2. Date of Death Month <u>04</u> - Day <u>20</u> - Year <u>96</u>		3. Time of Death <u>12:45AM</u>													
	4a. Facility Name (If not institution, give street and number) <u>Carroll County General Hospital</u>				4b. City, Town, or Location of Death <u>Westminster</u>		4c. County of Death <u>Westminster</u>													
Funeral Director	5. Social Security Number <u>212-36-9598</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Mar 15, 1909</u>													
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Carroll</u>		10c. City, Town or Location <u>Sykesville</u>													
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>7309 Second Avenue</u>		10f. Zip Code <u>21784</u>		10g. Citizen of What Country? <u>U.S.A.</u>													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housekeeping Manager</u>		16b. Kind of Business/Industry <u>Hotels-Atlantic and Quality Inn</u>															
	17. Father's Name (First, Middle, Last) <u>William Pobletts</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret E. Simmons</u>															
	19a. Informant's Name/Relationship (Type, Print) <u>Mrs. Nancy McFarland</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6610 Sweet Air Lane Sykesville, MD 21784</u>															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		Date <u>Apr 23</u>		20c. Location - City or Town, State <u>Woodlawn, MD</u>													
	21. Signature of Funeral Service Licensee <u>Steph M Jenkins</u>				22. Name and Address of Facility <u>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</u>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Urosepsis</u></td> <td rowspan="4">Approximate Interval Between Onset and Death <u>Days</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <u>Dehydration</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="4"><u>Days</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Urosepsis</u>	Approximate Interval Between Onset and Death <u>Days</u>	Due to (or as a consequence of):	b. <u>Dehydration</u>	Due to (or as a consequence of):	Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<u>Days</u>	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
	Immediate Cause (Final disease or condition resulting in death)	a. <u>Urosepsis</u>	Approximate Interval Between Onset and Death <u>Days</u>																	
Due to (or as a consequence of):																				
b. <u>Dehydration</u>																				
Due to (or as a consequence of):																				
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<u>Days</u>																		
	Due to (or as a consequence of):																			
	d.																			
	Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart Failure</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <u>Steph M Jenkins MD</u>				29c. License number <u>D44462</u>		29d. Date signed (Month, Day, Year) <u>04/20/96</u>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Nii Lante Lamptey-Mills, Carroll County General Hospital</u>																				
31. Date filed (Month, Day, Year) <u>APR 25 1996</u>																				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

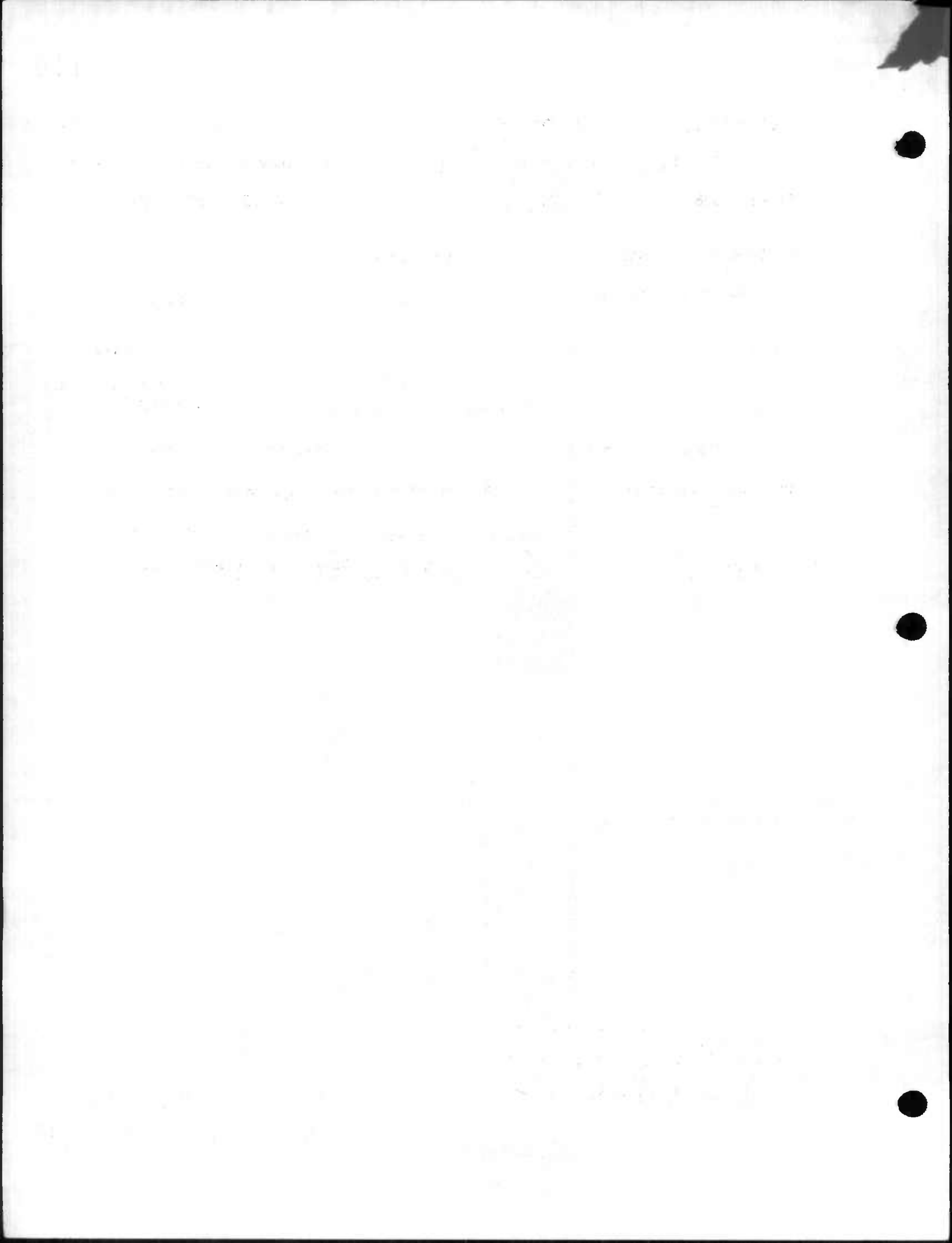
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12111

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS H KILEY				2. Date of Death Month Day Year APRIL 11, 1996		3. Time of Death 9:20 P																		
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A																		
Funeral Director	5. Social Security Number 130-10-8794		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 4, 1908																		
	9. Birthplace (State or Foreign Country) KANSAS, ILL.		10a. State PA.		10b. County LUZERNE		10c. City, Town or Location DALLAS																		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 439 ORCHARD W. NEWBERY ESTATE		10f. Zip Code 18612		10g. Citizen of What Country? U.S.A.																		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BANK PRESIDENT		16b. Kind of Business/Industry BANKING																				
	17. Father's Name (First, Middle, Last) JAMES PATRICK KILEY				18. Mother's Name (First, Middle, Maiden Surname) LOIS FAIRCHILD																				
	19a. Informant's Name/Relationship (Type, Print) ELIZABETH KILEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 439 ORCHARD WEST DALLAS, PA. 18612																				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MAPLE HILL CREMATORY		20c. Location - City or Town, State APR. 13 1996 HANOVER TOWNSHIP, PA.																				
	21. Signature of Funeral Service Licensee Thomas J. Skarda Jr.				22. Name and Address of Facility SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD 21224																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>myocardial infarction</td> <td>Due to (or as a consequence of):</td> <td>four days</td> </tr> <tr> <td>b.</td> <td>coronary artery disease</td> <td>Due to (or as a consequence of):</td> <td>five years</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	myocardial infarction	Due to (or as a consequence of):	four days	b.	coronary artery disease	Due to (or as a consequence of):	five years	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	myocardial infarction	Due to (or as a consequence of):	four days																				
b.		coronary artery disease	Due to (or as a consequence of):	five years																					
c.			Due to (or as a consequence of):																						
d.			Due to (or as a consequence of):																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)																									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORDON LEUNG, TOWER 110, JOHNS HOPKINS HOSPITAL 6601 WOLFE ST, BALTIMORE MD, 21287																									
31. Date filed (Month, Day, Year) APR 25 1996 32. Registrar's Signature [Signature]																									

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUSSELL L. KOOSER JR.</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>7:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>820 WASHBURN AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-30-3228</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>July 19, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>820 Washburn Avenue</b>				10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1957-1959 Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Steel Industry</b>		
17. Father's Name (First, Middle, Last) <b>Russell L. Kooser, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie E. Kissinger</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Russell B. Kooser / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>820 Washburn Avenue, Baltimore, MD 21225</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crownsville Veterans Cemetery, April 26, 1996, Crownsville, MD</b>		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, Maryland 21230</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>APRIL 23, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12113  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys M. Kelley</b>				2. Date of Death Month Day Year <b>April 17, 1996</b>		3. Time of Death <b>5:10 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2473 Braddock Road</b>				4b. City, Town, or Location of Death <b>Mt Airy</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>216-22-9043</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 3, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt Airy</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2473 Braddock Road</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Louis Henry Haley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ninnie B. Mills</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Judy Arterburn</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2473 Braddock Road Mt Airy, MD 21771</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		20c. Location - City or Town, State <b>Apr 19, Sykesville, MD</b>		20d. Date <b>96</b>	
	21. Signature of Funeral Service Licensee <i>Stephen M Jenkins</i>				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W Old Liberty Road Winfield, MD 21784</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Abdominal Aortic Aneurysm, Peripheral Vascular Disease, Osteoarthritis</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>A. V. M. MD</i>		29c. License number <b>D33184</b>		29d. Date signed (Month, Day, Year) <b>April 19, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>114 Business Center, Dover, Delaware Jonathan Kushner, MD</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12114

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTONIO LOPEZ</b>				2. Date of Death Month Day Year <b>APRIL 18 1996</b>		3. Time of Death <b>2215 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTH WEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-40-3330</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 29, 1924</b>	9. Birthplace (State or Foreign Country) <b>Spain</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Owings Mills</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>205 Cedarmere Circle</b>				10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Barber</b>		16b. Kind of Business/Industry <b>Trade</b>	
	17. Father's Name (First, Middle, Last) <b>Francisco Lopez</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Luisa Garvi</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dolores Lopez/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 Cedarmere Circle-Owings Mills, Maryland 21117</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>				22. Name and Address of Facility <b>State Anatomy board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ENDSTAGE COPD</b>							
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b>							
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>C. Ravi MD</b>			
	29c. License number <b>D37333</b>				29d. Date signed (Month, Day, Year) <b>APRIL 18, 1996</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>C. RAVI MD, NHC, BALTO. MD 21133</b>							
	31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <b>Davidson-Rendell</b>			
	33. Registrar's Signature							
	34. Registrar's Signature							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

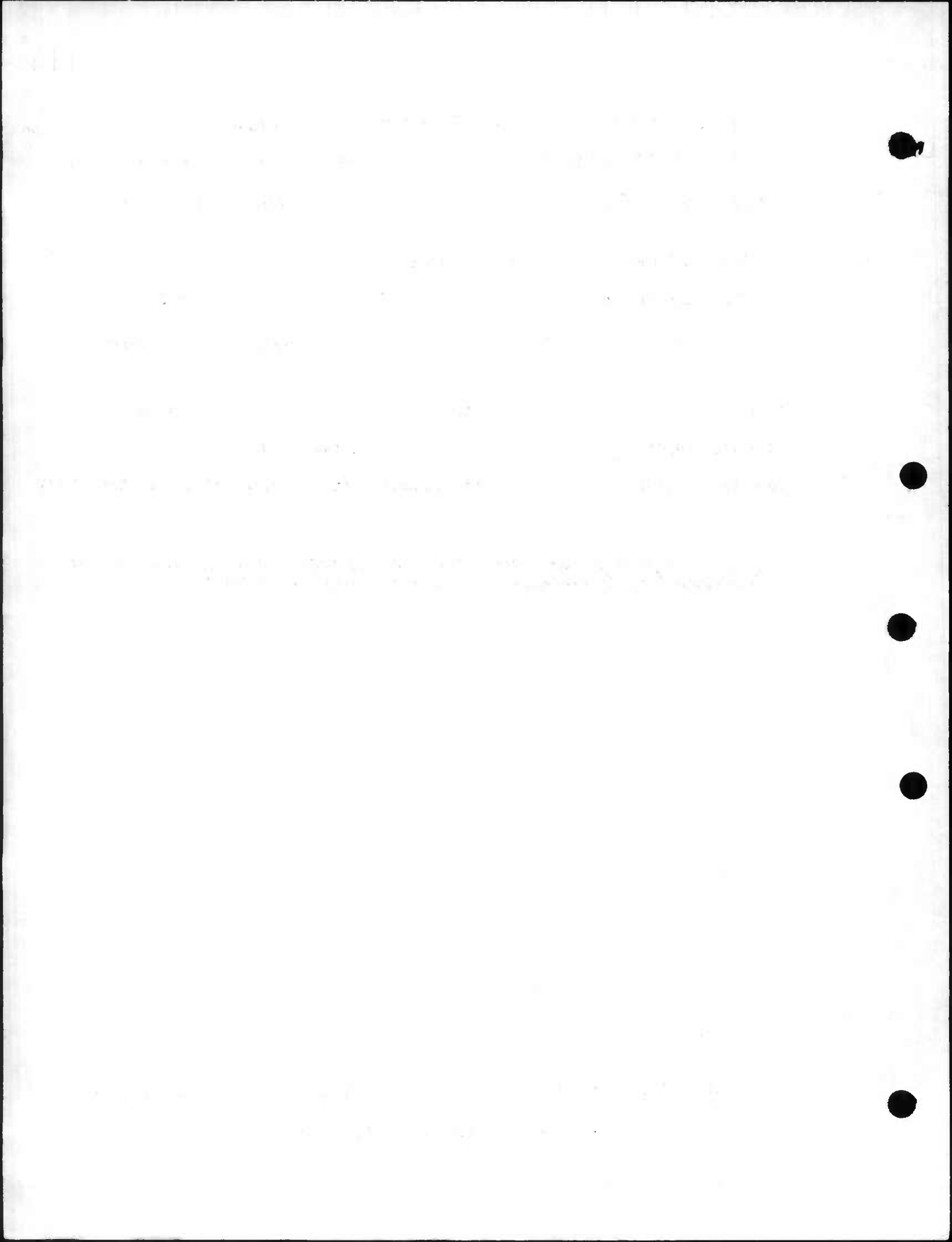
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12115

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JUNE LILLY</b>				2. Date of Death Month Day Year <b>APRIL 22 1996</b>		3. Time of Death <b>16:54 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Church Home Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-42-5349</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 29, 1933</b>		
	9. Birthplace (State or Foreign Country) <b>N. Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2003 E. Hoffman Street</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pile Driver Foreman</b>		16b. Kind of Business/Industry <b>Martin G.M. Imbach</b>		17. Father's Name (First, Middle, Last) <b>Tom Lilly</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Anna Lyles</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Portland L. Rucker</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2003 E. Hoffman Street, Baltimore, MD 21205</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL GARDENS 4-27 DUNDALK, MD</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. INTRACEREBRAL HEMORRHAGE</b> Due to (or as a consequence of): <b>b. HYPERTENSION</b> Due to (or as a consequence of): <b>c. DIABETES MELLITUS</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>YEARS</b> <b>YEARS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Mickey Valyasev MD.</b>		29c. License number <b>MD D45525</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>MICKEY VALYASEV MD CHURCH HOSPITAL BALTIMORE MARYLAND</b>		31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12116

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GREGORY LIBIN</b>				2. Date of Death Month <b>APRIL</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>3:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>5715 PARK HEIGHTS AVE., APT. 710</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-17-7948</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 9, 1908</b>	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5715 PARK HEIGHTS AVE., APT. 710</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>RUSSIA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NONE</b>		16b. Kind of Business/Industry <b>NONE</b>			
	17. Father's Name (First, Middle, Last) <b>MOSES LIBIN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>FRUMA AARON</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MRS. SARA LIBIN (WIFE)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5715 PARK HEIGHTS AVE, APT. 710 BALTIMORE, MD 21215</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW -</b>		20c. Location - City or Town, State <b>4-22-1996 REISTERSTOWN, MD</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Primary Carcinoma of Lung with metastasis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Carcinoma of Prostate</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier 		29c. License number <b>D02053</b>		29d. Date signed (Month, Day, Year) <b>4-21-96</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOSEPH DECKERBAUM, M.D. 3635 OLD COURT RD. BALTO. MD. 21208</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

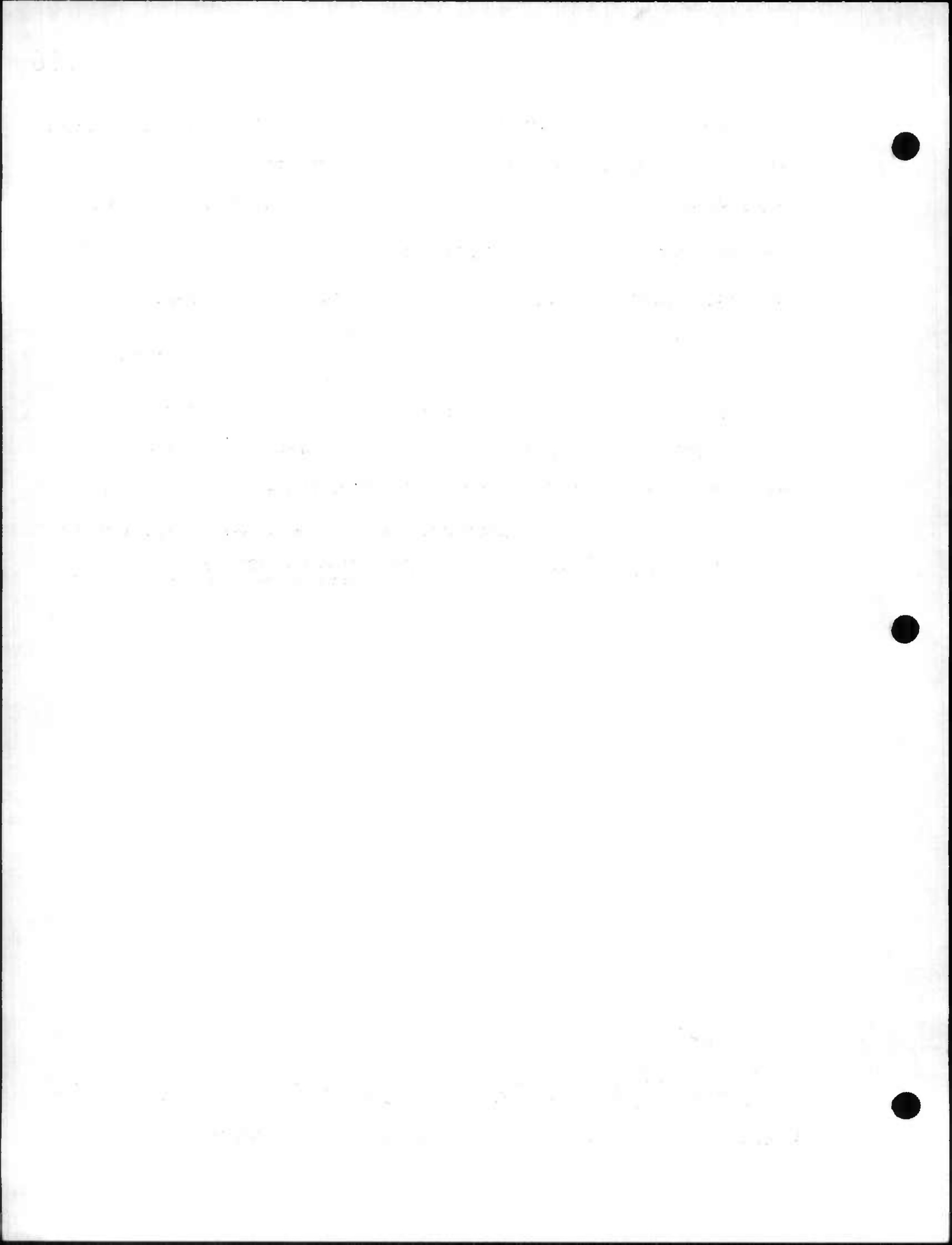
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar




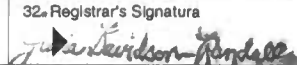
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12117

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dwaine Bascom Locklear</b>			2. Date of Death Month Day Year <b>April 19, 1996</b>		3. Time of Death <b>6:43 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1923 E. Baltimore Street</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-90-2582</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>29</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/04/1966</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1923 E. Baltimore Street</b>			10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>American Indian</b>
	15. Decedent's Education (Specify only highest grade completed) <b>9th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Counsellor</b>		16b. Kind of Business/Industry <b>Education</b>		
	17. Father's Name (First, Middle, Last) <b>Rodney Jacobs</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Deloris Locklear</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Margaret Locklear/Grandmother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>603 S. Ann Street Apt. 608, Baltimore, Md. 21231</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oxendine Cemetery</b>		Date <b>4/22/96</b>		20c. Location - City or Town, State <b>Robeson Co. N.C.</b>
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Maryland 21231</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Retroviral Illness</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Noah Lechtzin, M.D.</b>				29c. License number <b>M6316</b>		29d. Date signed (Month, Day, Year) <b>April 20, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Noah Lechtzin, Johns Hopkins Hospital, Baltimore, Maryland 21287</b>							
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12118

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Vincent G. Lanza</b>				2. Date of Death Month Day Year <b>April 22, 1996</b>		3. Time of Death <b>6:00 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>7310 Fairbrook Road Apt. 2B</b>				4b. City, Town, or Location of Death <b>Woodlawn</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-07-6382</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 15, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Ohio</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Woodlawn</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7310 Fairbrook Road Apt. 2B</b>		10f. Zip Code <b>21244</b>		
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Restaurant</b>		
17. Father's Name (First, Middle, Last) <b>Salvatore Lanza</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Agatha Agatha Giardina</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Agatha Joan Armalis</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3601 Kings Point Road Randallstown, MD 21133</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		Date <b>4/25/96</b>		20c. Location - City or Town, State <b>Sykesville, Maryland</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ischemic Cardiomyopathy</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>5 year</b> <b>20 year</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 		29c. License number <b>127034</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Tracy H. Copeland &amp; MO 5310 Old Court Road Suite 201 Randallstown MD 21133</b>		
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 		State Registrar		DHHM 16 Rev 6/95		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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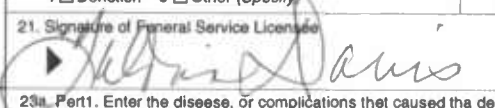
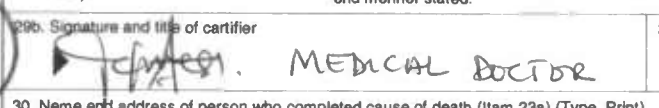
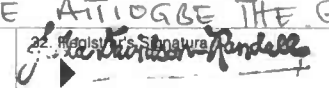
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12119

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINCOLN R. MATTHEWS				2. Date of Death Month Day Year APRIL 23 <sup>RD</sup> 1996			3. Time of Death 9:45 AM																									
	4e. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY			4c. County of Death n/a																									
Funeral Director	5. Social Security Number 214-24-7481		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth Month Day Year OCT. 27, 1915		9. Birthplace (State or Foreign) VIRGINIA																								
	Usual Residence of Decedent																																
10a. State md		10b. County n/a		10c. City, Town or Location baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																									
10e. Street and Number 1011 HALSTEAD ROAD				10f. Zip Code 21234		10g. Citizen of What Country? UNITED STATES																											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK																									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 <sup>th</sup> Collegia (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL LABORER			16b. Kind of Business/Industry BETHLEHEM STEEL CORP.																										
17. Father's Name (First, Middle, Last) CHARLES MATTHEWS					18. Mother's Name (First, Middle, Maiden Surname) MARY DUTTON																												
19e. Informant's Name/Relationship (Type, Print) PATRICIA MATTHEWS					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 HALSTEAD RD, APT. b-2, baltimore, MD #34																												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		Date 4-27		20c. Location - City or Town, State RANDALLSTOWN, MD																										
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AVENUE																												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ELECTROLYTE DISORDER</td> <td>WEEKS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>AORTIC VALVE DISEASE</td> <td>WEEKS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>DIABETES MELLITUS</td> <td>YEARS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>DILANTIN TOXICITY</td> <td>DAYS</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	ELECTROLYTE DISORDER	WEEKS	Due to (or as a consequence of):			b.	AORTIC VALVE DISEASE	WEEKS	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	DIABETES MELLITUS	YEARS	Due to (or as a consequence of):			d.	DILANTIN TOXICITY	DAYS	
Immediate Cause (Final disease or condition resulting in death)	a.	ELECTROLYTE DISORDER	WEEKS																														
	Due to (or as a consequence of):																																
	b.	AORTIC VALVE DISEASE	WEEKS																														
	Due to (or as a consequence of):																																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	DIABETES MELLITUS	YEARS																														
	Due to (or as a consequence of):																																
d.	DILANTIN TOXICITY	DAYS																															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA — WEEKS PROTEIN CALORIE MALNUTRITION — WEEKS								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MEDICAL DOCTOR		29c. License number P09306		29d. Date signed (Month, Day, Year) APRIL 23 <sup>RD</sup> 1996																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KWASHIE ATTIOGBE THE GOOD SAMARITAN HOSPITAL OF MARYLAND INC.																																	
31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature 																															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12120

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Kenneth McCoy-Sr</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>23</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>4:18 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>216-48-2620</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>46</i> YRS.		7. DATE OF BIRTH MONTH <i>Aug.</i> DAY <i>11</i> YEAR <i>1949</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Union Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto City</i>		9c. COUNTY OF DEATH <i>n/a</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>n/a</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>733 E. 23rd STREET</i>				10f. ZIP CODE <i>21218</i>		10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>8-27-69/7-2-71</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 th</i> College (1-4 or 5+) <i>-</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MAINTENANCE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>GAS &amp; ELECTRIC CO.</i>	
17. FATHER'S NAME (First, Middle, Last) <i>KEMP MC COY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARIE DUPREE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MARIE MC COY</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>733 E. 23 rd STREET, BALTIMORE, MD 21218</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GARRISON FOREST VA CEM. 4-26</i>		20c. LOCATION — City or Town, State <i>OWINGS MILLS, MD</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Valerie M. Davis</i>	
22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH.-1101 E. NORTH AVENUE</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>GI Bleed</i>				Approximate Interval Between Onset and Death <i>24 hrs.</i>			
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				b. <i>Esophageal Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):			
				c. DUE TO (OR AS A CONSEQUENCE OF):			
				d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alcohol Abuse</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elizabeth A. Bennett MD</i>				29c. LICENSE NUMBER <i>AT 2438946</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 23, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ELIZABETH A BENNETT 201 East University Parkway, Baltimore, MD 21218</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1996</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6+1



96 12121

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLENE Elaine MEDLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22 1996</b>		3. TIME OF DEATH <b>5:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-76-6692</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 26, 1936</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>JOSEPH RICHIE Hospice</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
11. COUNTY OF DEATH <b>N/A</b>				12. STATE <b>Maryland</b>		13. COUNTY OF DEATH <b>N/A</b>	
14. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		15. STREET AND NUMBER <b>515 Dolphin Street</b>		16. ZIP CODE <b>21217</b>		17. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
22. DECEASED'S EDUCATION (Specify only highest grade completed) <b>10th grade</b>		23. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		24. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>		25. FATHER'S NAME (First, Middle, Last) <b>JOHN MEDLEY, SR.</b>	
26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN CHASE</b>		27. INFORMANT'S NAME (Type/Print) <b>JOHN MEDLEY, JR.</b>		28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1717 Opinkett Ct Baltimore, Md 21237</b>		29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR Cemetery 4/26/96 Catonsville, Md</b>		31. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gray Lewis</b>		32. NAME AND ADDRESS OF FACILITY <b>CHATHAM - Harris Funeral Home 5540 Reisterstown Road Baltimore, Md 21215</b>		33. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
34. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial anoxia</b>		35. DUE TO (OR AS A CONSEQUENCE OF): <b>Inanition</b>		36. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>AIDS</b>		37. DUE TO (OR AS A CONSEQUENCE OF): <b>HIV infection</b>	
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		39. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		41. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
42. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		43. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>JB Richie Hospice</b>		44. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		45. DATE OF INJURY (Month, Day, Year)	
46. TIME OF INJURY <b>M</b>		47. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		48. DESCRIBE HOW INJURY OCCURRED		49. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
50. LOCATION (Street and Number or Rural Route Number, City or Town, State)		51. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		52. SIGNATURE AND TITLE OF CERTIFIER <b>T. Powell M.D.</b>		53. LICENSE NUMBER <b>D13006</b>	
54. DATE SIGNED (Month, Day, Year) <b>22 Apr 96</b>		55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas Powell, 101 W. Read St., Balto. Md. 21201</b>		56. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>		57. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

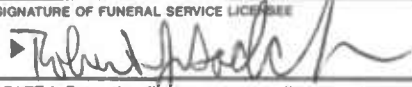
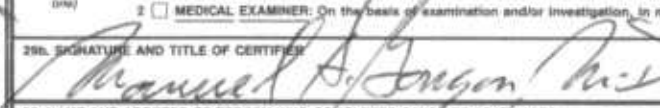





96 12122

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Vincent P. Muffoletto, Sr.</b>		2. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1996</b>		3. TIME OF DEATH <b>7:20 A.</b>	
4. SOCIAL SECURITY NUMBER <b>220-05-1226</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 10, 1923</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>9102 Hines Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>9102 Hines Road</b>		10f. ZIP CODE <b>21234</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrical Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Electrical Contracting Self-Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Muffoletto</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucia Provenza</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dora G. Muffoletto (wife)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9102 Hines Road, Baltimore, MD 21234</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate interval Between Onset and Death			
a. <b>Anemia Malnutrition Dehydration</b>		<b>Months</b>			
b. <b>Severe COPD</b>		<b>years</b>			
c. <b>ASCVD (S/P CABG '92)</b>		<b>years</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D04099</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-24-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>8321 BELAIR RD, BALTO, MD. 21236</b>					
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MILTON MITCHELL Mitchell</b>				2. Date of Death Month Day Year <b>APRIL 19, 1996</b>		3. Time of Death <b>22:50 P</b>		
	4a. Facility Name (If not Institution, give street and number) <b>3102 SUMTER AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
<b>Funeral Director</b>	5. Social Security Number <b>216-42-2955</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 20, 1944</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3102 Sumter Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U S A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> Collega (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SANITATION WORKER</b>		16b. Kind of Business/Industry <b>BALTO CITY SANATATION DEPT</b>			
17. Father's Name (First, Middle, Last) <b>Charles Felton</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Mitchell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gladys Mitchell -Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3102 Sumter Avenue Baltimore, Md 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PK</b>		Data <b>42796</b>		20c. Location - City or Town, State <b>RANDALLSTOWN MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Hypertensive Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <b>Partial</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how Injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>APRIL 20, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

96 12124

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERTHA MANSBACH</b>				2. Date of Death Month Day Year <b>APRIL 21 96</b>		3. Time of Death <b>5 30 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>MILFORD MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-14-7729</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 11, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>GERMANY</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>9 COBBLESTONE CT, APT. 1-B</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>BERNARD PHILIPPS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JETTCHEN OBERDORFER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MRS. IRENE RUSSEL (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8283 TOPPING RD. BALTIMORE, MD 21208</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESED - 4-22-1996- RANDALLSTOWN, MD</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>a. <b>peripheral vascular disease with gangrene</b> Due to (or as a consequence of):</p> <p>b. <b>congestive heart failure</b> Due to (or as a consequence of):</p> <p>c. <b>anemia due to recurrent GI bleeding</b> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 25%; text-align: center;"> <p>2xRS</p> <p>2xRS</p> <p>2xRS</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D 42956</b>		29d. Date signed (Month, Day, Year) <b>4/21/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>21 Crossroads Drive Suite 400 Owings Mills MD 21117</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State  
Registrar



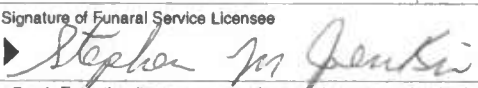
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary E. Marsiglia</b>				2. Date of Death Month Day Year <b>April 20, 1996</b>		3. Time of Death <b>6:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-68-8672</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 14, 1906</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>1 Smeton Place</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) Collegiate (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Anthony DiMarco</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosina Micciche</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Anthony G. Marsiglia (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1603 Woodling Way Baltimore, MD 21208</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		Date <b>Apr 23,</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory failure</b> Due to (or as a consequence of): b. <b>End-stage COPD</b> Due to (or as a consequence of): c. <b>Upper GI bleed</b> Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>V. Babushkins, MD</b>						
		29c. License number <b>D47772</b>		29d. Date signed (Month, Day, Year) <b>04/22/1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Victoria Babushkina, MD (BABUSHKINA) 1205 York Rd Lutherville, MD 21093</b>								
31. Date filed (Month, Day, Year) <b>04/22/96</b>		32. Registrar's Signature <b>APR 25 1996 John Davidson Randall</b>						

Baltimore, Maryland 21215-0020

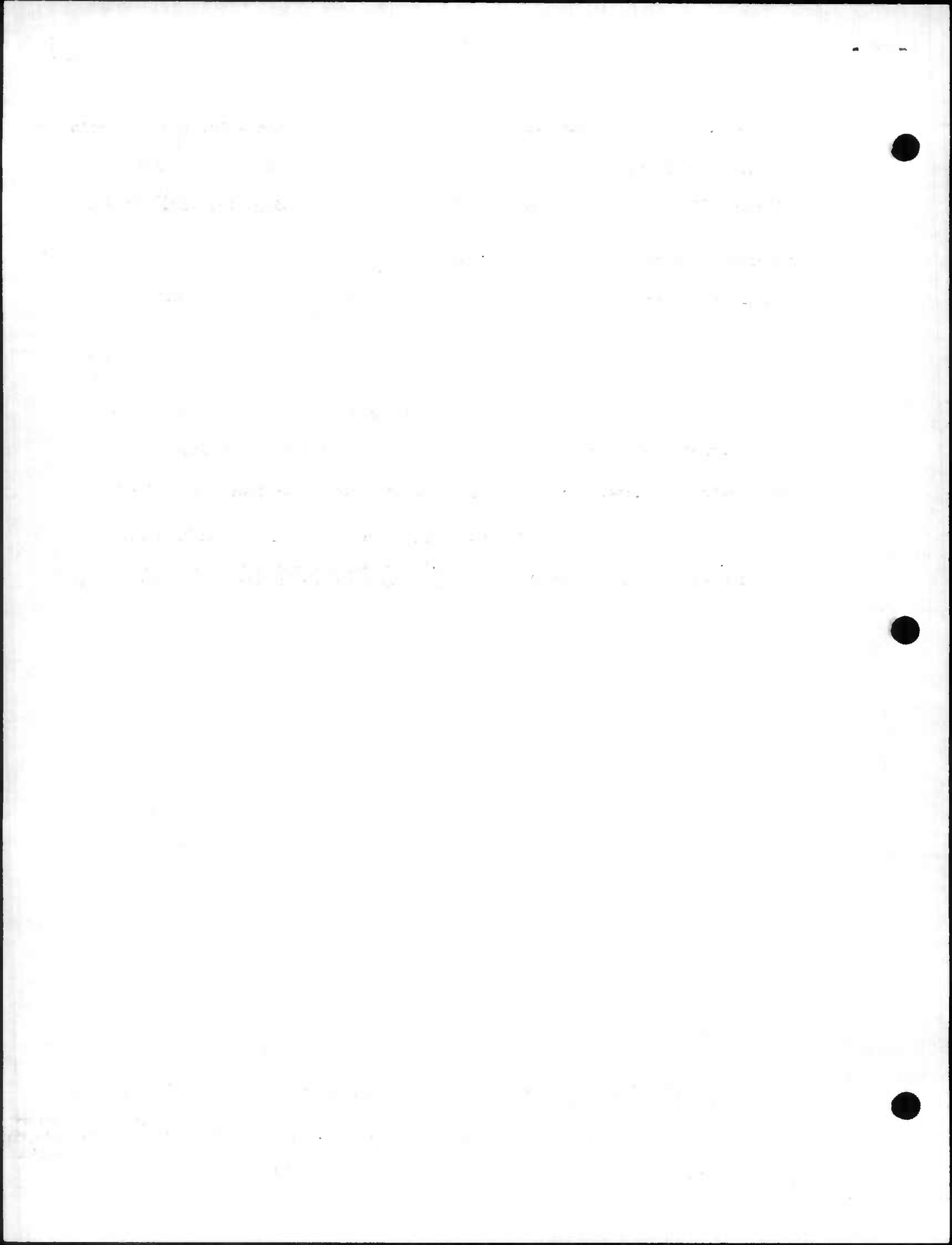
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12126

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN K MAGALSKI</b>				2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>5 AM</b>															
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>															
Funeral Director	5. Social Security Number <b>213-01-0430</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 31, 1916</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>														
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
	10e. Street and Number <b>616 BINSTED ROAD</b>				10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>UNITED STATES</b>															
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>															
	17. Father's Name (First, Middle, Last) <b>FRANK KOCHANSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SOPHIA MASLOWSKA</b>																	
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. EVELYN SCHNEIDER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10314 MALCOLM CIRCLE COCKEYSVILLE, MD 21030</b>																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEM. PK. APRIL 24, 1996 ELKRIDGE, MD</b>		20c. Location - City or Town, State																	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061</b>																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>ACUTE MYOCARDIAL INFARCTION</b></td> <td><b>1 DAY</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>CORONARY VASCULAR ACCIDENT</b></td> <td><b>1 WEEK</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>CONGESTIVE HEART FAILURE</b></td> <td><b>1 YEAR</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. <b>ATRIAL FIBILLATION</b></td> <td><b>1 YEAR</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>ACUTE MYOCARDIAL INFARCTION</b>	<b>1 DAY</b>	Due to (or as a consequence of):		b. <b>CORONARY VASCULAR ACCIDENT</b>	<b>1 WEEK</b>	Due to (or as a consequence of):		c. <b>CONGESTIVE HEART FAILURE</b>	<b>1 YEAR</b>	Due to (or as a consequence of):		d. <b>ATRIAL FIBILLATION</b>
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>ACUTE MYOCARDIAL INFARCTION</b>	<b>1 DAY</b>																				
	Due to (or as a consequence of):																					
	b. <b>CORONARY VASCULAR ACCIDENT</b>	<b>1 WEEK</b>																				
	Due to (or as a consequence of):																					
c. <b>CONGESTIVE HEART FAILURE</b>	<b>1 YEAR</b>																					
Due to (or as a consequence of):																						
d. <b>ATRIAL FIBILLATION</b>	<b>1 YEAR</b>																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, ANEMIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>028221</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID SCHNEIDER MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061</b>																						
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12127

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA <del>NORTON</del> Anna Norton</b>				2. Date of Death Month <b>03</b> Day <b>27</b> Year <b>96</b>		3. Time of Death <b>8:58 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MED. CENTER BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALT-CITY</b>	
Funeral Director	5. Social Security Number <b>220-14-3533</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03-16-30</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>7103 Dunshire Way, Apt. C-2</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 years</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Food Industry</b>		
17. Father's Name (First, Middle, Last) <b>Frank Bennett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma McCracker</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Diane McCrady</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8213 North Boundary Rd. Dundalk, Maryland 21222</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Mary Cem.</b>		Date <b>3/29/96</b>		20c. Location - City or Town, State <b>Dundalk, Maryland</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PNEUMONIA</b> Due to (or as a consequence of): b. <b>SMALL BOWEL OBSTRUCTION - chronic</b> Due to (or as a consequence of): c. <b>RADIATION THERAPY FOR VAGINAL CANCER</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>3 days</b> <b>5 months</b> <b>2 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>95003</b>		29d. Date signed (Month, Day, Year) <b>3-27-96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>HUGO BERTOLAZZI, JOHNS HOPKINS BAYVIEW MED CENTER</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12128

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leslie Merton Overholt</b>				2. Date of Death Month Day Year <b>Apr. 22, 1996</b>		3. Time of Death <b>4:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Meridian Multi-Medical</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-07-7188</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 18, 1909</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3811 Kimble Rd.</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NONE</b>			16b. Kind of Business/Industry <b>Balto. County Roads Commission</b>	
17. Father's Name (First, Middle, Last) <b>Merton Fenton Overholt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Overholt Hagepanos</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18618 York Rd., Parkton, MD 21120</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens</b>		Date <b>APRIL 25</b>		20c. Location - City or Town, State <b>Timonium, MD</b>
21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Myocardial Infarction</b> Due to (or as a consequence of): <b>IHD</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>&lt; 1 day</b> <b>&lt; 10 yr</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Depression</b> <b>- Parkinson Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <b>[Signature]</b>
29c. License number <b>D 41901</b>				29d. Date signed (Month, Day, Year) <b>4/23/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anisa Mirza, M.D., Russell Morgan Bldg., 5601 Loch Raven Blvd., 3rd Floor Balto., MD</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>								32. Registrar's Signature <b>[Signature]</b>

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12129

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Francis Peltz Sr				2. Date of Death Month Day Year April 21, 1996		3. Time of Death 11:03 A.M.			
	4a. Facility Name (If not institution, give street and number) Church Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 216-16-1277		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/10/1922	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 27 S. Linwood Ave.				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Storekeeper		16b. Kind of Business/Industry Chemical					
	17. Father's Name (First, Middle, Last) Andrew Peltz				18. Mother's Name (First, Middle, Maiden Surname) Anna Barna					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Stella Clafferty Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Queensway Ct. Bel Air, Maryland 21014					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 4/25/96	20c. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service licensee 				22. Name and Address of Facility David J. Weber Funeral Home 401 S. Chester Street Baltimore, Md 21231					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. lung mass Due to (or as a consequence of): c. lymphocytosis Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 weeks 2-3 weeks 1 month	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Carcinoma						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Richard C. Hui, MD		29c. License number D43273		29d. Date signed (Month, Day, Year) April 21, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard C. Hui 600 N. Wolfe street, Baltimore MD 21287										
31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12130

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERTRUDE MAY Provenza				2. Date of Death Month Day Year April 23 1996		3. Time of Death 1:23p.m.		
	4a. Facility Name (If not Institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
Funeral Director	5. Social Security Number 212-26-0031		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 09-26-1917		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County TALBOT		10c. City, Town or Location EASTON		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 41 PARKLANE 9632 KYDE PARK		10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME					
17. Father's Name (First, Middle, Last) LAWRENCE MUELLER				18. Mother's Name (First, Middle, Maiden Surname) GRACE MACHER					
19a. Informant's Name/Relationship (Type, Print) MYRTLE M. RUSSELL				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 DORCHESTER ROAD, PASADENA, MD. 21122					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		Date 4/26/96		20c. Location - City or Town, State GLEN BURNIE, MARYLAND			
21. Signature of Funeral Service Licensee				22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061					
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYOCARDIAL INFARCTION (IMMEDIATE) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LONG STANDING, ENOSTASIS RHEUMATIC VALVULAR HEART DISEASE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number D35259		29d. Date signed (Month, Day, Year) 4/23/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN O'KEEFE, M.D., 606 DUTCHMAN'S LANE, EASTON, MD. 21601									
31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12131

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAMAR MONROE STREVIG</b>				2. Date of Death Month <b>April</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>0715 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>176-05-2154</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug., 23, 1916</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10e. State <b>Maryland</b>		10b. County <b>Baltimore</b>	
10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>113 Melvin Avenue</b>		10f. Zip Code <b>21228</b>
10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Railroad</b>
17. Father's Name (First, Middle, Last) <b>Lloyd Henry Peter Strevig</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lizzie Shaffer</b>				19a. Informant's Name/Relationship (Type, Print) <b>Cheryl Hall/Daughter</b>
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Melvin Avenue-Baltimore, Maryland 21228</b>				20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Data</b>		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Dir.</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. RUPTURED ABDOMINAL AORTIC ANEURYSM 12 HOURS</b> Due to (or as a consequence of): <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>RESIDENT</b>				29c. License number <b>2056</b>
29d. Date signed (Month, Day, Year) <b>APRIL 17, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RONALD McLEAN 900 CATON AVE., BALTIMORE, MD. 21229</b>				
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <b>Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12132

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Derotha Elizabeth Spinner				2. DATE OF DEATH MONTH DAY YEAR APRIL 22 1996		3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 215-22-3514		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 7, 1914	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2451 BARCLAY STREET				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE		16b. KIND OF BUSINESS/INDUSTRY HOSPICE (home care)	
17. FATHER'S NAME (First, Middle, Last) HERMAN FALLIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BEATRICE MOODY			
19a. INFORMANT'S NAME (Type/Print) DEROTHA C. SPINNER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 E. 21 st. STREET, BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEM. 4-26		20c. LOCATION — City or Town, State ANNE ARUNDEL CO, md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Davis</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute tracheobronchitis DUE TO (OR AS A CONSEQUENCE OF): b. Abdominal carcinomatosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death hours months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel A. Symonds MD				29c. LICENSE NUMBER D20397		29d. DATE SIGNED (Month, Day, Year) April 23 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel A. Symonds Union Memorial Hospital Baltimore, MD							
31. DATE FILED (Month, Day, Year) APR 25 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

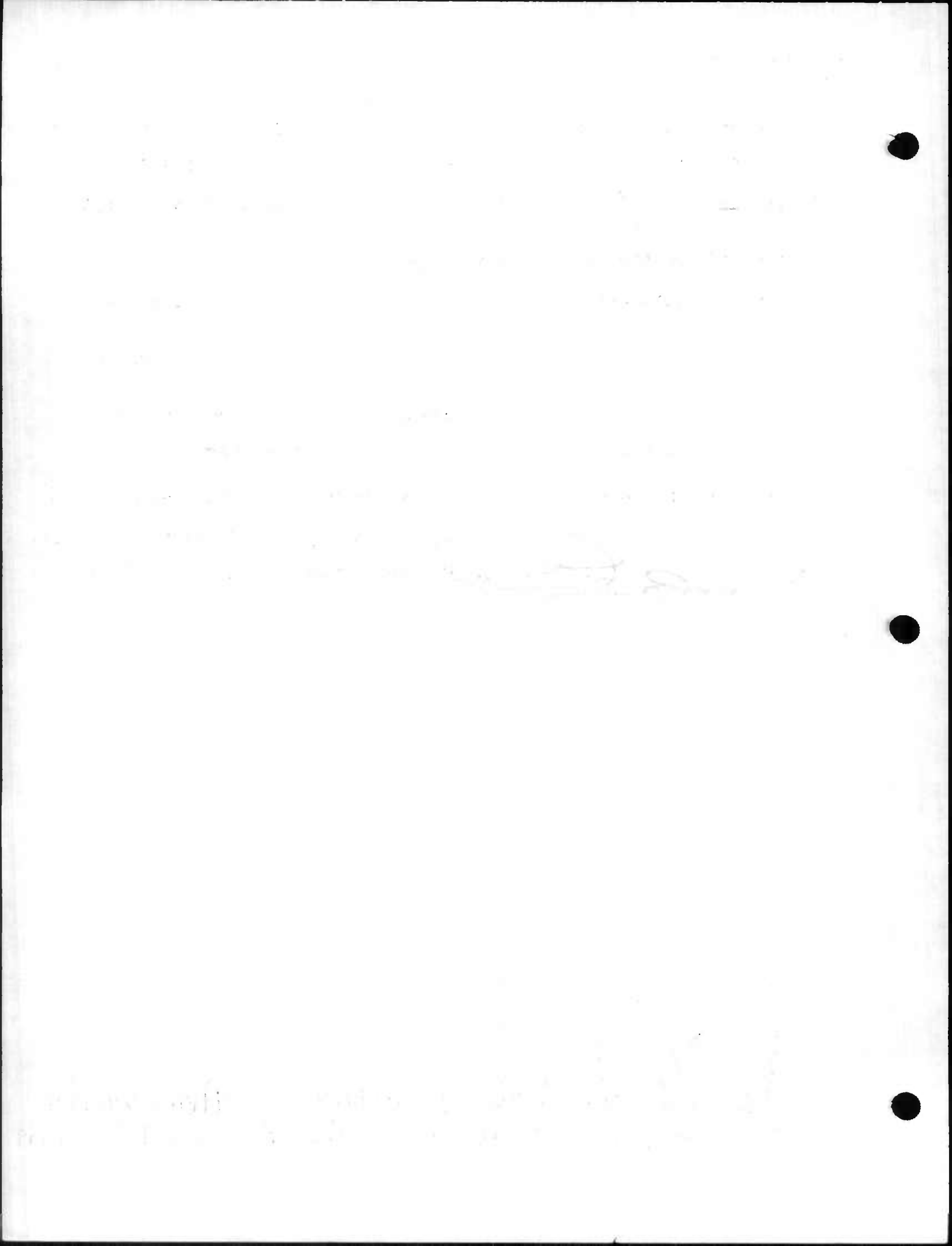
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Valmond E. Schneider</b>				2. Date of Death Month Day Year <b>April 23 1996</b>		3. Time of Death <b>7:15pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1164 Kelfield Drive</b>				4b. City, Town, or Location of Death <b>Halethorpe</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-05-1706</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 29, 1914</b>	
	Usual Residence of Decedent				9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Halethorpe</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1164 Kelfield Drive</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>salesman</b>		16b. Kind of Business/Industry <b>Household</b>	
	17. Father's Name (First, Middle, Last) <b>John E. Schneider</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna C. Grimes</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth Schneider, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1164 Kelfield Drive Halethorpe, Maryland 21227</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death) a. METASTATIC RENAL CELL CARCINOMA 2 YEARS</b> Due to (or as a consequence of): <b>Sequentially list conditions, if any, leading to immediate cause: Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>D19419</b>	
	29d. Date signed (Month, Day, Year) <b>APRIL 24, 1996</b>							
	30. Name and address of person who completed cause of death item 23e) (Type, Print) <b>DIANA H. GRIFFITHS 900 CATON AVE. BALTIMORE MD 21229</b>							
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 17 & 18 PER F.H. FILM  
G-735 5/7/96 t.t

State of Maryland / Department of Health and Mental Hygiene

96 12134

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN EMMETTE SMITH						2. Date of Death Month Day Year April 23 1996		3. Time of Death 10:10P											
	4a. Facility Name (If not institution, give street and number) Cromwell Center Genesis Elder Care						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore											
Funeral Director	5. Social Security Number 267-10-4506		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) June 14, 1912		9. Birthplace (State or Foreign Country) Texas											
	Usual Residence of Decedent																			
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number 102 Croftley Road				10f. Zip Code 21093		10g. Citizen of What Country? USA														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Captain			16b. Kind of Business/Industry U.S. Merchant Marines													
17. Father's Name (First, Middle, Last) <del>Unknown</del> GROVER JAMES GENTRY						18. Mother's Name (First, Middle, Maiden Surname) WILLIE MAE ARCHER														
19a. Informant's Name/Relationship (Type, Print) Catherine J. Smith Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Croftley Road Lutherville, Maryland 21093																
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		Date April 29		20c. Location - City or Town, State Baltimore, Maryland												
21. Signature of Funeral Service Licensee <i>Thomas Joseph Beck</i>				22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>CUA</i></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <i>2 days</i> <i>10 years</i></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>ASCD</i></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <i>CUA</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>2 days</i> <i>10 years</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>ASCD</i>	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <i>CUA</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>2 days</i> <i>10 years</i>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>ASCD</i>	Due to (or as a consequence of):																		
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier <i>James A. Quinlan</i>				29c. License number D-12950		29d. Date signed (Month, Day, Year) 7/24/96														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES A. QUINLAN, MD 7801 YORK RD Towson Md 21204																				
31. Date filed (Month, Day, Year) APR 25 1996				32. Registrar's Signature <i>[Signature]</i>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen Delano Sullivan</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 24 1996</i>		3. TIME OF DEATH <i>00:25 A M</i>	
4. SOCIAL SECURITY NUMBER <i>212-32-8729</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>91</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>February 12, 1905</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Union Memorial Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>2913 Crestmont Avenue</i>	
10f. ZIP CODE <i>21211</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Joseph Henry Delano</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ida Snyder</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Daniel N. Sullivan Jr</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1232 Gittings Avenue Baltimore, Maryland 21239</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery 4/27</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Annis Hayden Kenak</i>				22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</i>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery disease</i> c. <i>Atherosclerotic disease</i> d. <i>HTN</i>							Approximate Interval Between Onset and Death <i>1 hr</i> <i>5 years</i> <i>10 years</i> <i>20 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH</b> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Samara, M.D.</i>				29c. LICENSE NUMBER <i>AT 2438946</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/24/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Waiel Samara, Union Memorial Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1996</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



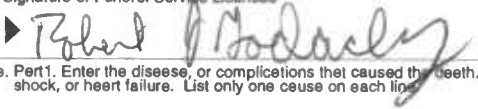
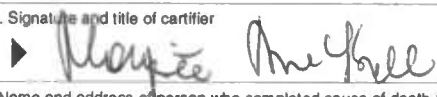
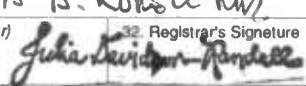
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12136

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY SMITH</b>						2. Date of Death Month Day Year <b>APRIL 17, 1996</b>		3. Time of Death <b>2206 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>LAUREL</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>301-20-5409</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 19, 1925</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>		
	Usual Residence of Decedent										
10a. State <b>Virginia</b>		10b. County <b>Rockingham</b>		10c. City, Town or Location <b>McGaheysville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>747 Flower Drive</b>				10f. Zip Code <b>22840</b>		10g. Citizen of What Country? <b>U. S. A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>University</b>				
17. Father's Name (First, Middle, Last) <b>John Smith</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Brittain</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Betty Jane Smith</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>747 Flower Dr., McGaheysville, Virginia 22840</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harrisonburg Crem. Ser.4/22/96</b>			20c. Location - City or Town, State <b>Harrisonburg, Virginia</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE INJURIES</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <b>4-17-96</b>		28b. Time of Injury <b>2122 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>PEDESTRIAN TRUCK BY MOTOR VEHICLE</b>		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 1 LAUREL RD HOWARD CO MD</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 18, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY ANN D. KORSCH MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12137

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles John STORRER</b>						2. Date of Death Month Day Year <b>April 19 1996</b>		3. Time of Death <b>12:30 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>219-18-1740</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1923</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Perry Hall</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>4202 Chapel Road</b>				10f. Zip Code <b>21128</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Airplane Mechanic</b>			18b. Kind of Business/Industry <b>Self-Employed</b>			
	17. Father's Name (First, Middle, Last) <b>John C. Storrer</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary K. Janik</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mildred Parlett (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2932 Northwind Road, Baltimore, MD 21234</b>						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>4/22/96</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>one hour</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 				29c. License number <b>D19793</b>		29d. Date signed (Month, Day, Year) <b>4/19/96</b>				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Howard Bond, M.D. 9000 Franklin Square Dr. Baltimore, MD 21237</b>										
	31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12138**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Thomas Smith</b>				2. Date of Death Month <b>APR</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>1 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Bel Air Nursing &amp; Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>214-03-2545</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 21, 1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4604 Shamrock Avenue</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4or 5+) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Warehouseman</b>			16b. Kind of Business/Industry <b>Martin Marietta</b>	
17. Father's Name (First, Middle, Last) <b>John F. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie M. Wilhelm</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Walter Smith (Brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1904 Parkwood Drive, Forest Hill, Md. 21050-2005</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>4/24/96</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Cancer - Lung</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>6 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier M.D.				29c. License number <b>D34652</b>		29d. Date signed (Month, Day, Year) <b>April 22, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. HASWELL 2 NORTH AVE BEL AIR MARYLAND 21014</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 				



96 12139

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Erin Michelle Schuck</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 23 1996</b>		3. TIME OF DEATH <b>3:15 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-25-4496</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>6</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/18/89</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>md</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Perry Hall</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>53 Gilliland Ct</b>		10f. ZIP CODE <b>21236</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dependent</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Never Worked</b>		17. FATHER'S NAME (First, Middle, Last) <b>William F. Schuck, Jr.</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Darlene A. Reid</b>				19a. INFORMANT'S NAME (Type/Print) <b>William F. Schuck, Jr.</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10e</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corporation 4/26/96 Towson, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald C. Schuck</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiogenic shock</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>20 min</b>							
b. <b>Gastrointestinal bleeding</b> <b>17 hrs</b>							
c. <b>VSD/pulmonary hypertension</b> <b>6 1/2 yrs</b>							
d. <b>Trisomy 18</b> <b>6 1/2 yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>Not applicable</b>		28b. TIME OF INJURY <b>NA</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED <b>NA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Starr MD</i> <b>B. Starr MD</b>				29c. LICENSE NUMBER <b>D33708</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Barnaby Starr, 201 East University Avenue, Balt., Md 21218</b>							
31. DATE OF DEATH (Month, Day, Year) <b>APR 23 1996</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Trudy Ellen Sutphin</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>24</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>11:00 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>194-38-8183</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>48</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 26, 1947</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>2103 Lamar Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Fallston</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2103 Lamar Court</b>	
10f. ZIP CODE <b>21047</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1 Year</b> College (1-4 or 5+) <b>Coordinator</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Coordinator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Essex Essex Community College</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Brent V. Belcher Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary K. Gathercole</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Leonard F. Sutphin (Husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2103 Lamar Court, Fallston, Maryland 21047</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 4/26/96</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Breast Cancer</b> Approximate Interval Between Onset and Death <b>5 years</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul Celano, MD</b>				29c. LICENSE NUMBER <b>D30929</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/25/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL CELANO, MD #205 6569 N. Charles St, BALTIMORE, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12



96 12141

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Wladyslawa Siwek</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>24</b> YEAR <b>96</b>		3. TIME OF DEATH <b>3:00</b> <b>A</b>	
4. SOCIAL SECURITY NUMBER <b>579-52-4903</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/16/1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Poland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph's Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Catonsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1222 Tugwell Drive</b>	
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4 2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Research Assistant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Wincenty Siwek</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maria E. Rajca</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Danuta Mikolajczyk Friend</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15320 Pine Orchard Dr. Apt 3B Silver Spring, Md 20906</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery 4/26</b>		20c. LOCATION - City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>David J. Weber Funeral Home 401 S. Chester Street Baltimore, Md 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b> Approximate Interval Between Onset and Death <b>3 years</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>ATHEROSCLEROTIC HEART DISEASE 10 yrs.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURE BORDER - POST BRAIN SURGERY 1981 CEREBRAL ANEURYSM, MULTIPLE MINOR STROKES.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>DO 6893</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. NELSON MCKAY, M.D. 4030 WOODLEY RD. ELLCOTT CITY, MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





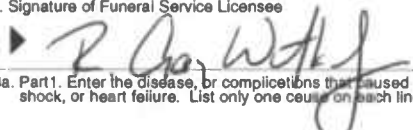
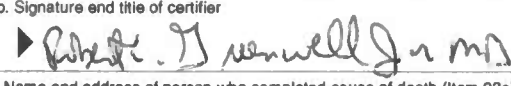

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12142

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER G SAVAGE</b>				2. Date of Death Month <b>Apr</b> Day <b>21</b> Year <b>1996</b>		3. Time of Death <b>10:21 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL Hospital</b>				4b. City, Town, or Location of Death <b>COLUMBIA, MD</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>182-16-3628</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 20, 1920</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2222 Mount Hebron Drive</b>				10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Westinghouse</b>		
17. Father's Name (First, Middle, Last) <b>Julius Savage</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Pencek</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy K. Savage (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21042 2222 Mount Hebron Drive Ellicott City, Maryland</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory April 23, 1996</b>		Date <b>April 23, 1996</b>		20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Witzke Funeral Home Of Catonsville Inc. 1630 Edmondson Avenue Catonsville, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>SEPTIS</b> Due to (or as a consequence of): b. <b>PERITONITIS</b> Due to (or as a consequence of): c. <b>CHRONIC Ambulatory Peritoneal Dialysis</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>24 hours</b> <b>8 Days</b> <b>1-1/2 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Vascular Disease</b> <b>Coronary Artery Disease</b> <b>Polycythemia</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Robert C. Greenwell Jr. MD</b>						
29c. License number <b>D34334</b>		29d. Date signed (Month, Day, Year) <b>Apr. 22 1996</b>						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert C. Greenwell Jr. MD 5999 Harpers Farm RD E-110 Columbia, MD 21044</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12143

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>THOMAS STEVENS</b>					2. Date of Death Month <b>APR</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>1800 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>St. Agnes Hospital</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>219-01-4528</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 8, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>410 Roanoke Drive</b>					10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1940-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>			16b. Kind of Business/Industry <b>Commercial</b>		
17. Father's Name (First, Middle, Last) <b>Wilmer Stevens</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Fisher</b>				
19e. Informant's Name/Relationship (Type, Print) <b>Thomas Donald Stevens (Son)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 Roanoke Drive Catonsville, Maryland 21228</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory April 23, 1996</b>			20c. Location - City or Town, State <b>Catonsville, Maryland</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Witzke Funeral Homes Of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>PNEUMONIA</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>5 min</b>  <b>3 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>  <b>PROSTATE CANCER</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Kongsak Chantornsang, M.D.</b>					29c. License number <b>PG-9145</b>		29d. Date signed (Month, Day, Year) <b>APR 22, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>KONGSAK CHANTORNSANG, M.D. ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MD</b>									
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JA

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12144

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Barbara Julia Seboda</b>				2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>4:15 AM</b>																				
	4a. Facility Name (If not institution, give street and number) <b>1100 Newfield Road</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>																				
Funeral Director	5. Social Security Number <b>217-07-8321</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec, 23, 1911</b>																				
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>																				
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
	10e. Street and Number <b>1100 Newfield Road</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>																				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>																						
	17. Father's Name (First, Middle, Last) <b>William Cowman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Bersterman</b>																						
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara L. Seboda (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1100 Newfield Road Baltimore, Maryland 21207</b>																						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>																						
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Witzke Funeral Homes Of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland</b>																								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>recurrent colon cancer</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>8 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td rowspan="4"></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>recurrent colon cancer</b>	Approximate Interval Between Onset and Death <b>8 years</b>	Due to (or as a consequence of):		b.		Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.			Due to (or as a consequence of):		d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a.	<b>recurrent colon cancer</b>	Approximate Interval Between Onset and Death <b>8 years</b>																								
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	b.																										
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	d.																										
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		29c. License number <b>D40850</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229</b>																											
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>		32. Registrar's Signature 																									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12145

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THEDA SHIPLEY				2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 7:20P													
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A													
Funeral Director	5. Social Security Number 213-10-3317	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 24, 1915		9. Birthplace (State or Foreign Country) MD.												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
	10e. Street and Number 632 S. DECKER AVE.			10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry SHOE FACTORY														
	17. Father's Name (First, Middle, Last) JOHN WILHELM				18. Mother's Name (First, Middle, Maiden Surname) LILLIAN DRINKWATER															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) LEWIS SHIPLEY			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 S. FASLEY ST. BALTIMORE, MD. 21224																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY REDEEMER CH.		Date APR 24 1996		20c. Location - City or Town, State BALTO. MD.													
	21. Signature of Funeral Service Licensee Phonias Sharda			22. Name and Address of Facility SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224																
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. cardiogenic Shock.</td> <td>Due to (or as a consequence of):</td> <td>2 hours</td> </tr> <tr> <td>b. Myocardial Infarction</td> <td>Due to (or as a consequence of):</td> <td>24 hours</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. cardiogenic Shock.	Due to (or as a consequence of):	2 hours	b. Myocardial Infarction	Due to (or as a consequence of):	24 hours	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. cardiogenic Shock.	Due to (or as a consequence of):	2 hours																	
	b. Myocardial Infarction	Due to (or as a consequence of):	24 hours																	
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier [Signature] MD		29c. License number N2474		29d. Date signed (Month, Day, Year) April 20th, 1996																
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Abenaa Brewster Johns Hopkins Hospital																				
31. Date filed (Month, Day, Year) APR 25 1996		32. Registrar's Signature [Signature]																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12146

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CAMPBELL SAMUEL

2. Date of Death

Month Day Year  
APRIL 20 1996

3. Time of Death

2:40AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

214-38-0287

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 8, 1942

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4511 Pennington Ave.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Welding Ship Yard

17. Father's Name (First, Middle, Last)

Forrest

Samuel

18. Mother's Name (First, Middle, Maiden Surname)

Margaret

Irwin

19a. Informant's Name/Relationship (Type, Print)

Deborah Sampson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1318 Abington Rd. Abington, Md. 21009

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory Inc.

Date

4/22/96

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stallings Funeral Home PA  
3111 Mountain Rd. Pasadena, Md. 2112223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BRAIN HERNIATION

Approximate  
Interval Between  
Onset and Death

4 Hours

Due to (or as a consequence of):

b. CEREBELLAR HAEMORRHAGE

4 Hours

Due to (or as a consequence of):

c. ALCOHOL ABUSE

30 YEARS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER, CHRONIC LIVER DISEASE,

ASCITES, PORTAL HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] INTERN - PGY-I

29c. License number

AS2441614-13

29d. Date signed (Month, Day, Year)

APRIL 20 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBEEN IQBAL HARBOR HOSPITAL CTR, 3001 SOUTH HANOVER ST, BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12147

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAURICE J. SMITH				2. Date of Death Month Day Year APRIL 23, 1996		3. Time of Death 1548 PM	
	4a. Facility Name (If not institution, give street and number) 200 EAST MADISON STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death City	
Funeral Director	5. Social Security Number 216-30-5186		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 7-19-1935	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County City		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 104 E. Gittings Street		10f. Zip Code 21230		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) watchman		16b. Kind of Business/Industry Baltimore City			
	17. Father's Name (First, Middle, Last) John Joseph Smith				18. Mother's Name (First, Middle, Maiden Surname) Edna Moon			
	19a. Informant's Name/Relationship (Type, Print) step Pauline Bradford daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 159 Cross Junction, Virginia 22625			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 4-27-96 Baltimore, Md.			
	21. Signature of Funeral Service Licensee <i>Daniel A. Taylor</i>				22. Name and Address of Facility McCully Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Dennis J. Chute MD</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) APRIL 24, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) APR 25 1996				32. Registrar's Signature <i>Davidson Handell</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12148

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN LEO SCHAUB

2. Date of Death

Month Day Year  
APRIL 23 1996

3. Time of Death

6:34 pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-18-6485

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Dec. 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7504 Kenlea Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Frances Leo Schaub

18. Mother's Name (First, Middle, Maiden Surname)

Anna Unknown Markert

19a. Informant's Name/Relationship (Type, Print)

Mary Margaret Schaub/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7504 Kenlea Avenue, Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

4/27/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller, Inc.  
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute pulmonary edema

6 days

Due to (or as a consequence of):

b. Congestive Heart Failure

years

Due to (or as a consequence of):

c. Coronary artery disease

year

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

025205

29d. Date signed (Month, Day, Year)

4/24/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G BMC 6701 N. Charles Street, Balto. Md 21204

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

John A. Davidson

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12149

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hannah Evelyn Taylor				2. Date of Death Month Day Year 04 20 1996		3. Time of Death 4:00 AM		
	4a. Facility Name (If not institution, give street and number) Stella Maris 2300 Dulaney Valley Road				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 226-70-7061		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) March 27, 1913	9. Birthplace (State or Foreign Country) West Virginia			
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Timonium		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 3 Dale Crest Court Apt. 104				10f. Zip Code 21093		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nine -----		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service		16b. Kind of Business/Industry Restaurant				
	17. Father's Name (First, Middle, Last) Milton Hankins				18. Mother's Name (First, Middle, Maiden Surname) Laura Sparks				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Bowman- daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Dale Crest Court Apt. 104 Timonium, Md. 21093				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sherwood Memorial Park		Date 04/23/96		20c. Location - City or Town, State Salem, Virginia		
	21. Signature of Funeral Service Licensee Lowell M. Lemmon				22. Name and Address of Facility 10 W. Padonia Road Timonium, Maryland 21093				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>CARDIO PULMONARY ARREST</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>MUSCULOSKELETAL INJURIES</i>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Robert L. Hattum MD		29c. License number D34622		29d. Date signed (Month, Day, Year) 4/20/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10940 York Rd Henric, MD 21074									
31. Date filed (Month, Day, Year) 4/20/96		32. Registrar's Signature John Davidson Radlett							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12150

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Uttenreither

2. Date of Death

April 24, 1996

3. Time of Death

4:20 am

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-32-1842

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

01/19/1907

9. Birthplace (State or Foreign Country)

White

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

912 Southridge Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Fabiszak

18. Mother's Name (First, Middle, Maiden Surname)

Ida Unknown

19a. Informant's Name/Relationship (Type, Print)

James Uttenreither Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1304 Pine Ridge La Baltimore, Md 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

4/27

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Home

5311 Edmondson Ave Baltimore, Md 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia, left-sided

Due to (or as a consequence of):

b. Congestive heart failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

five days

Six days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertrophic cardiomyopathy

peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☒ No

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26d. Describe how injury occurred

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kris E. Kuhl M.D.

29c. License number

D 37464

29d. Date signed (Month, Day, Year)

April 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRIS E. KUHLMAN, M.D. 3320 Benson Avenue Baltimore, MD 21227

31. Date filed (Month, Day, Year)

APR 25 1996

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-2222.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 12151

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY FRANCES VOLLEY</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>15</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>10:15 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>577-10-1471</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 22, 1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Wesley Retirement Homes</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTRY OF DEATH <b>n/a</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2211 W. Rogers Avenue</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Claims Examiner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Insurance</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Hester Martin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriet C. Carlton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Harriett Schuette/Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2706 Dale Court-Baldwin, Maryland 21013</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald S. Wade, Dir.</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHRONIC ASPIRATION</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ALZHEIMER'S DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>WEEKS</b> <b>YEARS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert E. Volley M.D.</b>				29c. LICENSE NUMBER <b>D-19425</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/16/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2211 W. ROGERS AVE. BALTIMORE, MD. 21209.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1996</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





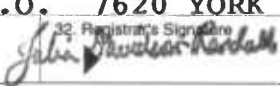
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT WEIL</b> Robert Lawrence Weil				2. Date of Death Month Day Year <b>04 21 1996</b>		3. Time of Death <b>11:28 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>388-18-0682</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 23, 1917</b>	9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TIMONIUM</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3 Dodworth Court</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chemist</b>		16b. Kind of Business/Industry <b>Food Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Lawrence Weil</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattye Lichtenstein</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Robert L. Weil (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Dodworth Ct., Timonium, MD 21093</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>24 APR</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>		
21. Signature of Funeral Service Licensee  <b>LOWELL M. LEMMON</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CARDIAC ARREST</b> Due to (or as a consequence of):  b. <b>VENTRICULAR TACHYCARDIA</b> Due to (or as a consequence of):  c. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>2 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier  <b>Alice Hsieh, D.O.</b>				29c. License number <b>H 43974</b>		29d. Date signed (Month, Day, Year) <b>Apr 21, 96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALICE HSIEH, D.O. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12153  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERMAN S. WOLF</b>						2. Date of Death Month Day Year <b>APRIL 22 1996</b>		3. Time of Death <b>1235 PM</b>				
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>				
Funeral Director	5. Social Security Number <b>213-10-8506</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 22, 1908</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>4001 CLARKS LANE, APT. 414</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>			16b. Kind of Business/Industry <b>RETAIL</b>					
	17. Father's Name (First, Middle, Last) <b>ISRAEL WOLF</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE GOLDBERG</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. MARCIA WOLF (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4001 CLARKS LANE, APT. 414 BALTIMORE, MD 21215</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH HAMEDROSH HAGODOL -</b>		Date <b>4-23-1996-</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>						
	21. Signature of Funeral Service Licensee <b>Allen Levine</b>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Recurrent Pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate interval Between Onset and Death <b>WKS</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>Matthew M. Nabney MD</b>				29c. License number <b>D45757</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MATTHEW M. NABNEY 2434 W. Belvedere Beach, MD</b>													
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>										32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12154

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Whipple</b>				2. Date of Death Month <b>April</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>10:55 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Ivy Hall Geriatric Center</b>				4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>013-24-9956</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 4, 1900</b>	9. Birthplace (State or Foreign Country) <b>Illinois</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3722 Red Grove Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>File Rater</b>			16b. Kind of Business/Industry <b>Insurance Company</b>	
17. Father's Name (First, Middle, Last) <b>Carl Mohr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Samuels</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marilyn Aldrich (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3722 Red Grove Road Middle River, Md. 21220</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory 4/25/1996</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PNEUMONIA.</b>								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD, CAD, ANEMIA - iron deficiency, DISPNOEA OSTEOARTHRITIS, RECURRENT urinary tract infection, N-G tube fed.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number <b>017148</b>		29d. Date signed (Month, Day, Year) <b>4-24-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>4706 HARFORD RD. BALTO., MD 21214, Donato A. Vargas, Jr.</b>								
31. Date filed (Month, Day, Year) <b>APR 23 1996</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

2. The second part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

3. The third part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Evelyn Williams</u>				2. DATE OF DEATH MONTH DAY YEAR <u>April 17, 1996</u>				3. TIME OF DEATH <u>6:30 A.M.</u>					
4. SOCIAL SECURITY NUMBER <u>217-22-1249</u>				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>79</u> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <u>Dec 11, 1916</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Caton Manor</u>						9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>			9c. COUNTY OF DEATH <u>N/A</u>				
10a. STATE <u>Maryland</u>				10b. COUNTY <u>N/A</u>				10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3010 Elizabeth Avenue</u>						10f. ZIP CODE <u>21230</u>			10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>9</u> Elementary/Secondary (9-12) <u>College (1-4 or 5+)</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Grament Worker</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Greif Brothers</u>					
17. FATHER'S NAME (First, Middle, Last) <u>John D. Duke</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary P. Price</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Mr. Thomas E. Long-Son</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3010 Elizabeth Ave., Baltimore, Md. 21230</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery April 20, '96</u>				20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kevin E. Ecker</u>				22. NAME AND ADDRESS OF FACILITY <u>McCully Funeral Home of Brooklyn</u> <u>237 E. Patapsco Ave., Balto., Md. 21225</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CEREBROVASCULAR ACCIDENT</u>												10 DAYS	
DUE TO (OR AS A CONSEQUENCE OF): <u>HYPERTENSION</u>													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
DUE TO (OR AS A CONSEQUENCE OF):													
DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC ATRIAL FIBRILLATION</u> <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Attending</u>						29c. LICENSE NUMBER <u>D 21776</u>			29d. DATE SIGNED (Month, Day, Year) <u>APRIL 17, 1996</u>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>SURYA P. MONDRA MD 203 EAST PATAPSCO Av. BALTIMORE 21225</u>													
31. DATE FILED (Month, Day, Year) <u>APR 25 1996</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12156

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian (NMN) Watkins</b> <del>LILLIAN WATKINS</del>				2. Date of Death Month Day Year <b>APRIL 24 1996</b>		3. Time of Death <b>7:45 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL 301 Glen Burnie</b>				4b. City, Town, or Location of Death <b>Anne Arundel Co</b>		4c. County of Death <b>Anne Arundel Co</b>	
Funeral Director	5. Social Security Number <b>217-18-0541</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04-16-1910</b>	9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>
	Usual Residence of Decedent				10a. State <b>MD.</b>		10b. County <b>ANNE ARUNDEL</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>210 BERTRAM CIRCLE</b>		10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>UNKNOWN</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RE EXAMINER</b>		16b. Kind of Business/Industry <b>COMFY SLIP COVERS</b>		
17. Father's Name (First, Middle, Last) <b>MEMS STOTTLEMIRE</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>JENNIE ALICE BOLYARD</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SHARON ROGERS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 BERTRAM CIRCLE, GLEN BURNIE, MD. 21060</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. myocardial infarction</b> Due to (or as a consequence of):  <b>b. </b> Due to (or as a consequence of):  <b>c. </b> Due to (or as a consequence of):  <b>d. </b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> <b>congestive heart failure</b>						Approximate Interval Between Onset and Death <b>6 days</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>congestive heart failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				
29c. License number <b>D43977</b>				29d. Date signed (Month, Day, Year) <b>April 24<sup>th</sup> 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Angela Okunji 301 Hospital Drive Glen Burnie MD 21061</b>								
31. Date filed (Month, Day, Year) <b>APR 25 1996</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-528-9028.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALEXANDER ZEBRASKI Joseph Zebraski</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>26</b> YEAR <b>96</b>		3. TIME OF DEATH <b>0035A M</b>	
4. SOCIAL SECURITY NUMBER <b>187-12-7039</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/10/1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>John Hopkins Bayview Medical Ctr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Balt. City</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>823 Loalan Avenue</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12 years</b> College (1-4 or 5+) <b>Foreman</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Foreman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Anthony Zebraski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine Gawonska</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Dorothy Zebraski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>823 Loalan Avenue Dundalk, Maryland 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cemetery 3/28/96 Dundalk, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>BALLO</b>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>10 days</b> <b>YEARS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Hugo Buterzi M.D.</b>				29c. LICENSE NUMBER <b>95003</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-26-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HUGO BUTERZI, JOHNS HOPKINS BAYVIEW MEDICAL CENTRE, BALT. MD 21224</b>							
31. DATE FILED (Month, Day, Year) <b>APR 2 5 1996</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12158

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>FATIMA ASHAI</u>						2. Date of Death Month <u>April</u> Day <u>23</u> Year <u>1996</u>		3. Time of Death <u>8:05 PM</u>	
	4a. Facility Name (If not institution, give street end number) <u>The Johns Hopkins Hospital</u>						4b. City, Town, or Location of Death <u>BALTIMORE CITY</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>077-82-6163</u>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>2</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <u>April 25, 1993</u>		9. Birthplace (State or Foreign Country) <u>Saudi Arabia</u>		10a. State <u>Maryland</u>		10b. County <u>Prince George's</u>		10c. City, Town or Location <u>Lanham</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>9859 Good Luck Road, #8</u>		10f. Zip Code <u>20706</u>		10g. Citizen of What Country? <u>Pakistan</u>		11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Asian</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0</u> College (1-4or 5+) <u>College</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Child</u>	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) <u>Wajahat Hassan Ashai</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Neelam Ashai</u>		19a. Informant's Name/Relationship (Type, Print) <u>Wajahat Hassan Ashai</u>		19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <u>same as #10</u>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>George Washington Cemetery</u>		Date <u>4/24/1996</u>		20c. Location - City or Town, State <u>Adelphi, Maryland</u>		21. Signature of Funeral Service Licensee <u>Donald V. Borgwardt</u>	
Physician /Medical Examiner	22. Name and Address of Facility <u>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</u>		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>Ventricular Arrhythmias</u> Due to (or as a consequence of): <u>Inborn Error in Metabolism</u> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>Lactic Acidosis</u>		Approximate Interval Between Onset and Death <u>18 hours</u> <u>3 YEARS</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Adult Type Respiratory Distress Syndrome</u> <u>Lactic Acidosis</u>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
State Registrar	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Keith U...</u>		29c. License number <u>D45825</u>		29d. Date signed (Month, Day, Year) <u>April 23, 1996</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>KEITH KOCIS, MD The Johns Hopkins Hospital, BALTIMORE Maryland</u>	
31. Date filed (Month, Day, Year) <u>APR 26 1996</u>		32. Registrar's Signature <u>Johi Shuckor-Randell</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 12159

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anne Lockett Andrew				2. DATE OF DEATH MONTH April DAY 12 YEAR 1996		3. TIME OF DEATH 6:10 P M	
4. SOCIAL SECURITY NUMBER 216-05-0097		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 13, 1912	
8. BIRTHPLACE (State or Foreign Country) Baltimore				9a. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
9b. FACILITY NAME (If not institution, give street and number) Riverview Nursing Centre, Inc.							
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1 Eastern Blvd. Baltimore, Maryland				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Operator		16b. KIND OF BUSINESS/INDUSTRY W.R. Grace Company			
17. FATHER'S NAME (First, Middle, Last) Edward Lockett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Betz			
19a. INFORMANT'S NAME (Type/Print) Eleanor Lockett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Colgate Avenue, Baltimore, Maryland 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade, Dir.</i>		22. NAME AND ADDRESS OF FACILITY State Anatomy Board - 655 W. Baltimore St. Baltimore, Maryland 21201-1559					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Aspiratory Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia, Hypertension</u> <u>colonic carcinoma</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Schwartz</i>				29c. LICENSE NUMBER D18667		29d. DATE SIGNED (Month, Day, Year) 4-13-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Schwartz 606 Hammonds Lane, Baltimore, Maryland 21225							
31. DATE FILED (Month, Day, Year) APR 26 1996				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12160

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELLEN AKERS</b>				2. Date of Death Month Day Year <b>APRIL 24, 1996</b>		3. Time of Death <b>6:53 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MD.</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-20-9440</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 10, 1919</b>	9. Birthplace (State or Foreign Country) <b>Scotland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rosedale</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1213 64th Street</b>				10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meatpacker</b>			16b. Kind of Business/Industry <b>Esskay</b>	
17. Father's Name (First, Middle, Last) <b>Peter Fleming</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanie Dunbar</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Patricia M. Hoffert</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6517 Cleveland Ave. Baltimore MD. 21222</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>			20c. Location - City or Town, State <b>4/29/96 Rossville Md.</b>		
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>					22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>3 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Francis Khoo</b>			29c. License number <b>D30263</b>		29d. Date signed (Month, Day, Year) <b>04-24-96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHOO, M.D., ST. JOSEPH MEDICAL CENTER</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>			32. Registrar's Signature <b>Don Handall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

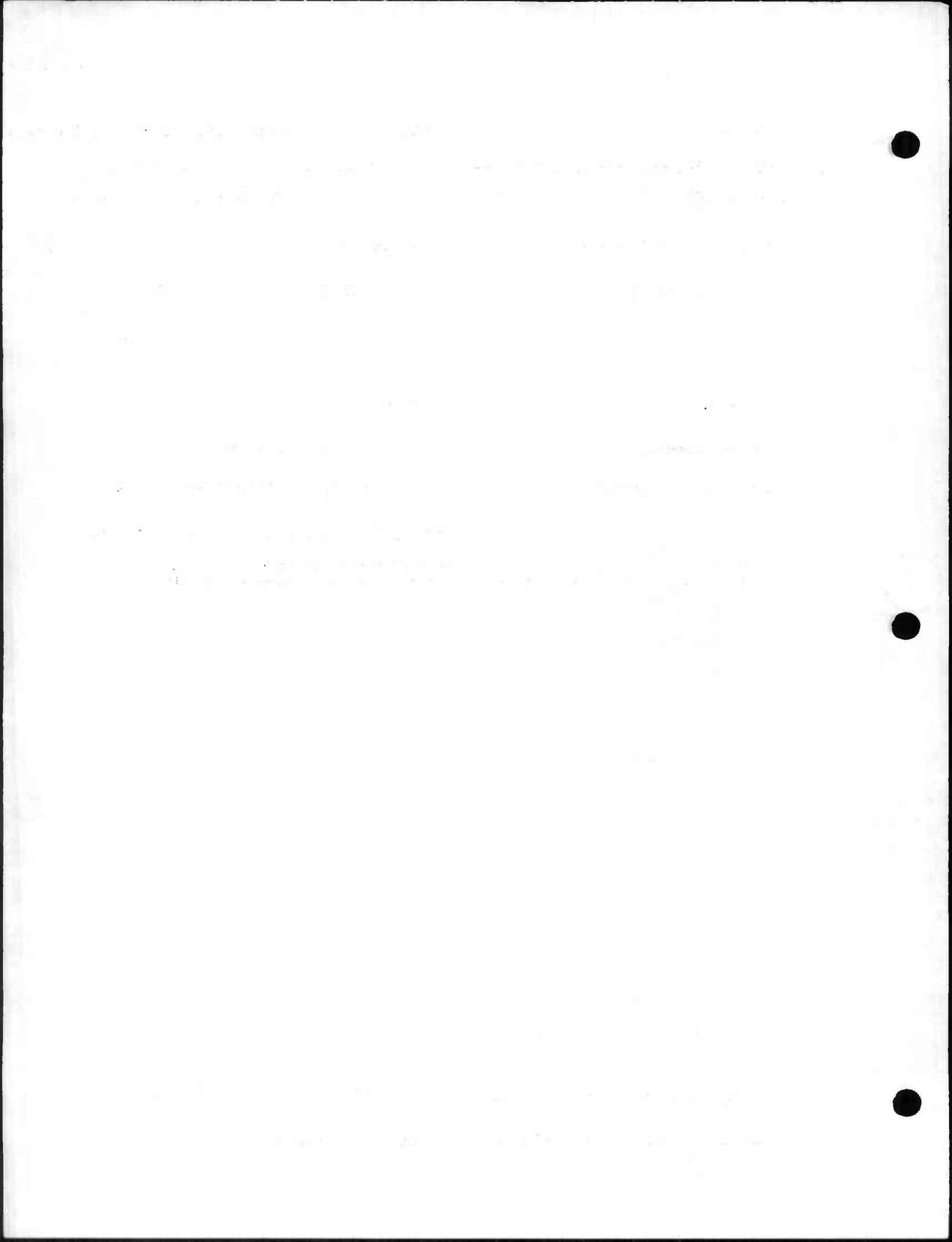
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12161

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP D. BECKNER				2. Date of Death APRIL 23 1996		3. Time of Death 5:43 A	
	4a. Facility Name (If not institution, give street and number) 3105 OAKLEY AVE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 219-84-4581		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 33 Yrs.		8. Date of Birth (Month, Day, Year) SEP. 14, 1962	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location FOREST HILL	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1816 HIGH POINT ROAD		10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 YRS. College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMP. - PAINTER		16b. Kind of Business/Industry HOME IMPROVEMENT			
	17. Father's Name (First, Middle, Last) ANDREW J. BECKNER, SR.				18. Mother's Name (First, Middle, Maiden Surname) MARY JANE GRASSO			
	19a. Informant's Name/Relationship (Type, Print) BRIAN K. LUCINA				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 3805 WEST CHAPEL ROAD ABERDEEN, MARYLAND			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BELAIR MEMORIAL		20c. Location - City or Town, State APRIL 27 1996 BELAIR, MARYLAND			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR, P.A. 3 NEWPORT DRIVE FOREST HILL, MARYLAND 21050			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of Arm and Chest Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 4/23/96		28b. Time of injury 1:45 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred Subject Shot		28e. Place of injury - At home, term, street, tectory, office building, etc. (Specify) DU CAL		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3105 OAKLEY AVE.				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number O.CME		29d. Date signed (Month, Day, Year) APRIL 23, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature Julia [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

96 12162

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTHER THERESA BETTIEN				2. Date of Death Month Day Year APRIL 25 1996		3. Time of Death 1: 55 AM	
	4a. Facility Name (If not institution, give street and number) BEL FOREST NURSING CENTER				4b. City, Town, or Location of Death FOREST HILL		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 213-28-0779A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 30 1911	
	9. Birthplace (State or Foreign Country) ITALY		10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location BELAIR	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 300 SUNFLOWER DRIVE		10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS		16b. Kind of Business/Industry CLOTHING INDUSTRY			
	17. Father's Name (First, Middle, Last) SALVATORE ANZALONE		18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE SGRO		19. Informant's Name/Relationship (Type, Print) FRANCIS. J. SWARTZ			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH		20c. Location - City or Town, State APRIL 27 BALTIMORE MD		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>cerebral vascular accident</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval Between Onset and Death one month eight months		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mark J Wild MD	
	29c. License number 235522		29d. Date signed (Month, Day, Year) APRIL 25, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK WILD 2 NORTH AVENUE BELAIR MARYLAND 21014		31. Date filed (Month, Day, Year) APR 26 1996	
State Registrar	32. Registrar's Signature Julia Madison-Randall		33. Date of Death APR 25 1996		34. Time of Death 1: 55 AM		35. Cause of Death Pneumonia	
	36. Place of Death HARFORD		37. County of Death HARFORD		38. City, Town, or Location of Death BELAIR		39. Zip Code 21014	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

96 12163

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glennie Booth				2. Date of Death Month Day Year April 22, 1996		3. Time of Death 3:45 PM	
	4e. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 216-56-9361		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) Sept 10, 1951	
	9. Birthplace (State or Foreign Country) N.C.		10a. State md		10b. County NIA		10c. City, Town or Location Balto	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 6811 Fairlawn Ave		10f. Zip Code 21215	
	10g. Citizen of What Country? U. S. A				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th NIA	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Worker				16b. Kind of Business/Industry State of md		17. Father's Name (First, Middle, Last) Edgar C. Hall	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Glennie Yelverton				19a. Informant's Name/Relationship (Type, Print) Glennie E. Hall - mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 Rubin Ave Balto,	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 4/27/96 Woodlawn, md	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Sharon Stokes				22. Name and Address of Facility March F.H. West 4300 Wabash Ave			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxemia Due to (or as a consequence of): Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 72 hours Two years							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Anne M. Peterman, MD				29c. License number A52402321AP9938		29d. Date signed (Month, Day, Year) April 22, 1996	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Avenue Baltimore, Maryland 21215							
	31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature Son Hendell			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12164

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn F. Bremer

2. Date of Death

Month Day Year  
April 23, 1996

3. Time of Death

7:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Cherrywood Manor Nursing Home

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore Co.

5. Social Security Number

212-10-3190

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 15, 1910 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore Co.

10c. City, Town or Location

Glyndon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4806 Butler Rd

10f. Zip Code

21071

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Post office

17. Father's Name (First, Middle, Last)

Samuel Frazier

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Siegrist

19a. Informant's Name/Relationship (Type, Print)

Katherine W. Warner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Albright Ave. Glyndon, MD 21071

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Druid Ridge Cemetery

Date

4/26/96

20c. Location - City or Town, State

Pikesville, MD

21. Signature of Funeral Service Licensee

James B. Elin

22. Name and Address of Facility

11824 Reisterstown Rd.

Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARRHYTHMIA

Due to (or as a consequence of):

MINS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death): Last

b. HYPOXIA

Due to (or as a consequence of):

3 YRS

c. INTERSTITIAL FIBROSIS

Due to (or as a consequence of):

5 YRS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip N. Phelps MD

29c. License number

D36908

29d. Date signed (Month, Day, Year)

APR. 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11722 REISTERSTOWN RD. REISTERSTOWN, MD 21136

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12165

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys Magdalene Brooks</b>				2. Date of Death Month Day Year <b>April 25, 1996</b>		3. Time of Death <b>5:00am</b>	
	4e. Facility Name (If not Institution, give street and number) <b>1222 E. Riverside Ave.</b>				4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-18-3150</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 21, 1902</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
Usual Residence of Decedent								
10a. State <b>Md.</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Essex</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>1222 E. Riverside Ave.</b>			10f. Zip Code <b>21221</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>own home</b>			17. Father's Name (First, Middle, Last) <b>Jarrett Price</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ford</b>			19a. Informant's Name/Relationship (Type, Print) <b>William Brooks</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1222 E. Riverside Ave. Baltimore MD. 21221</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>			20c. Date <b>4/27/96</b>		
20d. Location - City or Town, State <b>Rossville Md.</b>			21. Signature of Funeral Service Licensee <b>R. Terry Connolly</b>			22. Name and Address of Facility <b>Connolly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>		
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY INSUFFICIENCY</b>								
23b. Approximate Interval Between Onset and Death <b>12 HOURS</b>								
23c. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. <b>HYPERTENSION, ATRIAL FIBRILLATION DEMENTIA, ANEMIA, PEPTIC ULCER DISEASE</b>								
23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>John J. Loh D.O.</b>		
29c. License number <b>H35593</b>			29d. Date signed (Month, Day, Year) <b>APRIL 25, 1996</b>			30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. JOHN J. LOH, 1124 MACE AVE., BALTIMORE, MD. 21221</b>		
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>			32. Registrar's Signature <b>Don Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

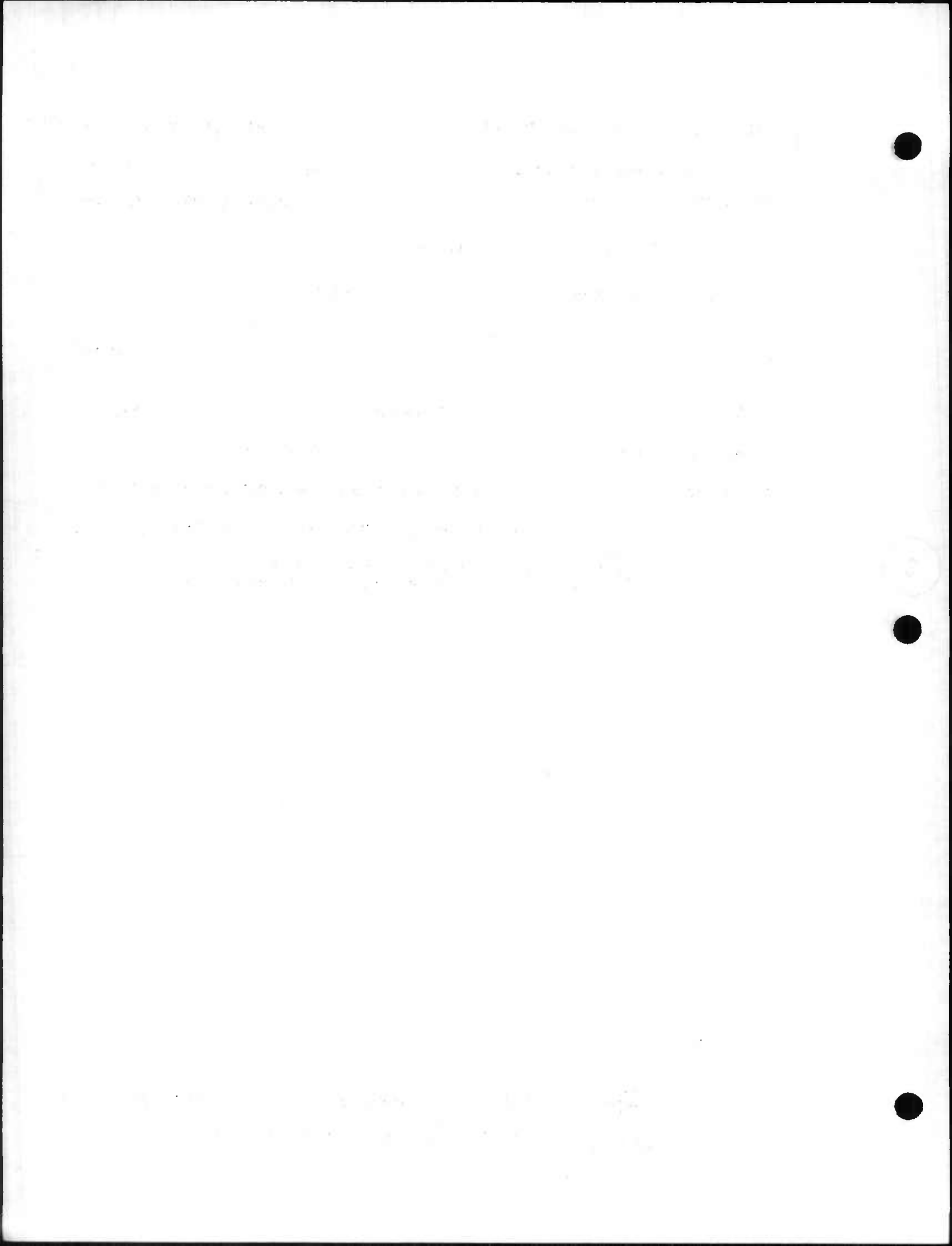
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12166

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>LILLIAN Ruth Bruce</u>				2. Date of Death Month <u>April</u> Day <u>23</u> Year <u>96</u>				3. Time of Death <u>0255</u>				
	4a. Facility Name (If not institution, give street and number) <u>Carroll County General Hospital</u>				4b. City, Town, or Location of Death <u>Westminster</u>				4c. County of Death <u>Carroll</u>				
Funeral Director	5. Social Security Number <u>219 58 5409</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>78</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 24, 1917</u>		9. Birthplace (State or Foreign Country) <u>Md.</u>				
	Usual Residence of Decedent				10a. State <u>Md.</u>				10b. County <u>Carroll</u>		10c. City, Town or Location <u>Sykesville</u>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <u>6317 Georgetown Blvd.</u>				10f. Zip Code <u>21784</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>High School</u> College (1-4 or 5+) <u>-</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Saleslady</u>				16b. Kind of Business/Industry <u>Avon</u>				
	17. Father's Name (First, Middle, Last) <u>Ernest A. Marling</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Martha F. Nixon</u>								
	19a. Informant's Name/Relationship (Type, Print) <u>William E. Bruce Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2405 Haight Ave. Sykesville, Md 21784</u>								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u>		Date <u>4/26/96</u>		20c. Location - City or Town, State <u>Baltimore, MD.</u>				
	21. Signature of Funeral Service Licensee <u>Harry W. Haight</u>				22. Name and Address of Facility <u>Haight Funeral Home</u> <u>P.O. Box 195 Sykesville, Md. 21784</u>								
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>sepsis</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>1 Day</u>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>N. Mowbradden, M.D.</u>				29c. License number <u>D46358</u>		29d. Date signed (Month, Day, Year) <u>April 23, 1996</u>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>N. Mowbradden, Carroll County Gen Hosp, Westminster, MD 21157</u>													
31. Date filed (Month, Day, Year) <u>APR 26 1996</u>				32. Registrar's Signature <u>John Paulsen</u>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

9611302747 UNIT # 16-19-23  
BRUCE, LILLIAN RUTH  
MFO ER, PHYSICIANS  
07/24/1917 F 04/22/96  
EMR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12167

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>LAURENCE E. COLLINS, JR.</u>				2. Date of Death Month <u>APRIL</u> Day <u>20</u> Year <u>1996</u>		3. Time of Death <u>3 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>2704 SARAH LANE</u>				4b. City, Town, or Location of Death <u>LARNEY</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>215-09-3926</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>77</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>APRIL 8, 1919</u>	
	9. Birthplace (State or Foreign Country) <u>OHIO</u>		10a. State <u>MARYLAND</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>LARNEY</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>2704 SARAH LANE</u>		10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 YRS.</u> College (1-4 or 5+) <u>4 YRS.</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>ENGINEERING</u>		16b. Kind of Business/Industry <u>MARTIN MARIETTA</u>			
	17. Father's Name (First, Middle, Last) <u>LAURENCE E. COLLINS, SR.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>RUTH LINS</u>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>PATRICIA D. COLLINS</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2704 SARAH LANE LARNEY, MARYLAND 21234</u>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GREEN MOUNT CEMETERY</u>		20c. Location - City or Town, State <u>1996 BALTIMORE, MARYLAND</u>		20d. Date of Disposition <u>APRIL 22</u>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>EVAN CHAPEL OF MEMORIALS</u> <u>8800 HARBOR ROAD - PARKVILLE</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Lymphoma</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <u>18 YRS</u>
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <u>Charles A. Padgett MD</u>				29c. License number <u>D15546</u>		29d. Date signed (Month, Day, Year) <u>APRIL 22, 1996</u>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. CHARLES A. PADGETT, M.D. 5601 LOCH RAVEN BLVD.</u>							
	31. Date filed (Month, Day, Year) <u>APR 26 1996</u>				32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12168

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KATHERINE D. CRUMP

2. Date of Death

04 20 96

3. Time of Death

3:50pm

4a. Facility Name (If not institution, give street and number)

U OF MD HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

217 38 5225

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 1, 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1274 LEONARDO ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10YRS

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

CLEANERS

17. Father's Name (First, Middle, Last)

William W. Warner, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Walker

19a. Informant's Name/Relationship (Type, Print)

CAROL A. CRUMP

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1274 LEONARDO ROAD BALTIMORE MARYLAND 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FAULTON UNITED METHODIST CHURCH

Data

APR 24 1996

20c. Location - City or Town, State

FAULTON, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES  
8800 HARFORD ROAD - PARKVILLE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver failure  
Chronic hepatitis C

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D48071

29d. Date signed (Month, Day, Year)

04/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOANG VI TRAN 22 S. GREENE ST., BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

Julia Harrison-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12169

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA CLAYLAND				2. Date of Death Month Day Year APRIL 23, 1996				3. Time of Death 6:30 pm		
	4a. Facility Name (If not institution, give street and number) 2126 CHANTILLA ROAD				4b. City, Town, or Location of Death CATONSVILLE				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 214-04-9474		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) JULY 26, 1908		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 2126 CAHTILLA ROAD				10f. Zip Code 21228				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS				16b. Kind of Business/Industry TEXTILE			
17. Father's Name (First, Middle, Last) WALLERY BENEWICZ				18. Mother's Name (First, Middle, Maiden Surname) ROSALIA TISKA							
19a. Informant's Name/Relationship (Type, Print) FRANK DAY / EXECUTOR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2142 CHANTILLA ROAD, CATONSVILLE, MARYLAND 21228							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Data APR. 26, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND					
21. Signature of Funeral Service Licensee <i>James J. Phillips</i>				22. Name and Address of Facility LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>CORONARY ARTERY DISEASE</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 10 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>TYPE II DIABETES MELLITUS</i> <i>HYPERTENSION</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>James J. Phillips, MD</i>				29c. License number D36231		29d. Date signed (Month, Day, Year) April 25, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>6565 NORTH CHARLES STREET SUITE 411 TOWSON, MD 21204</i>											
31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature <i>Don-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96-086  
96-2185-510  
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 12170

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHERRIE LAZETTE CHANDLER</b>				2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>12:35 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>606 W. LEXINGTON STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>041-66-7081</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>23</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC 17, 1972</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>27 CHEVIOT CT APT 27A</b>				10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>3yrs</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNIT CLERK</b>		16b. Kind of Business/Industry <b>JOHNS HOPKINS HOSP</b>			
	17. Father's Name (First, Middle, Last) <b>DENNIS CHANDLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CYNTHIA RIVERIA</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>CYNTHIA RIVERIA/MOTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27 CHEVIOT CT. WOODLAWN, MD. 21244</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PK. 4/29</b>		Date		20c. Location - City or Town, State <b>ARBUTUS, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO., MD 21213</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Contused Gunshot Wound of Head</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>UNK</b>		28b. Time of Injury <b>UNK</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot self</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NIGHT CLUB</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>608 W. Lexington St.</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 23, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JTA PEN WICK, MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Filmg, 734, item #24a, 25, 4/26/96, cyw, per dr.

## Certificate of Death

Reg. No.

96 12171

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert L. Carter</b>				2. Date of Death Month <b>April</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>11:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BelForest Nursing &amp; Rehab. Center</b>				4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>220-07-3074</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 18, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Fork, Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Kingsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11600 Stocksdales Road</b>		10f. Zip Code <b>21087</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Builder</b>		16b. Kind of Business/Industry <b>Self-Employed</b>			
	17. Father's Name (First, Middle, Last) <b>J. Leonard Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Golden Mast</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Melvin J. Carter (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11524 Stocksdales Rd. Kingsville, Md. 21087</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BelAir Memorial Gardens</b>		Date <b>April 15, 1996</b>		20c. Location - City or Town, State <b>BelAir, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>E. F. Lassahn</i>				22. Name and Address of Facility <b>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>end stage ischemic cardiomyopathy</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes</i> <i>peripheral vascular disease</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>David S. Dunn</i>				29c. License number <b>D32295</b>		29d. Date signed (Month, Day, Year) <b>Apr. 12 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID S. DUNN 15 W. MacPhail</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12172

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa C. Darago

2. Date of Death

Month Day Year  
April 24, 1996

3. Time of Death

4:00 P.M.

4a. Facility Name (If not institution, give street and number)

319 S. Castle Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-20-0952

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06/06/1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

319 S. Castle Street

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Stanley Kowalewski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Piorkowski

19a. Informant's Name/Relationship (Type, Print)

Raymond Murphy Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 S. Castle Street Baltimore, Md 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

4/27

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Home

401 S. Chester Street Baltimore, Maryland 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic adenocarcinoma, L1

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Pain

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36814

29d. Date signed (Month, Day, Year)

4/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7505 OGDEN DRIVE SUITE 504 TOWSON MD 21204

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12173

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hattie Day</b>				2. Date of Death Month <b>April</b> Day <b>24</b> Year <b>96</b>		3. Time of Death <b>4:24 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>		
Funeral Director	5. Social Security Number <b>214-30-2861</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 4, 1928</b>		
	10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>740 West Poplar Grove Street</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> Collage (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Baltimore Public Sch</b>		
17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Flora Edge</b>					
19e. Informant's Name/Relationship (Type, Print) <b>Robin A. Witherspoon</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7802 Jody Knoll Road Baltimore, Maryland 21244</b>					
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Data <b>Apr 29</b>		20c. Location - City or Town, State <b>Baltimore County, MD</b>		
21. Signature of Funeral Service Licensee <b>Ernest R Terry</b>				22. Name and Address of Facility <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <div style="display: flex; align-items: flex-start;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):</p> <p>b. <b>Severe coronary heart disease</b> Due to (or as a consequence of):</p> <p>c. <b>Diabetic cardiomyopathy</b> Due to (or as a consequence of):</p> <p>d. <b>Severe chronic obstructive lung disease</b></p> </div> </div>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Insulin dependent Diabetes Mellitus</b> <b>Obesity</b> <b>Depression</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Ernest R Terry</b>		29c. License number <b>D18327</b>		29d. Date signed (Month, Day, Year) <b>4/24/96</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Moges Gebremariam 4660 Wilkens Ave #203, Balto md 21229</b>									
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature <b>J. Davidson-Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar





96 12174

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Melanie Ann Eubanks</b>		2. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1996</b>		3. TIME OF DEATH <b>1109 A.M.</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>1 24 March 1, 1996</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. STREET AND NUMBER <b>2</b>		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>William Earl Eubanks</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Brenda Howard</b>			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3202 Wickers Rd Balt Md 21216</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SINAI 3-4 96</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sinai Hosp</b>		22. NAME AND ADDRESS OF FACILITY <b>2401 W. BELVEDERE AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>prematurity</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <b>1 hour</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Justin MD</b>		29c. LICENSE NUMBER <b>AS2402321 HG9918</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 1 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H Ginter, Sinai Hospital 2401 W Belvedere Ave, Baltimore MD</b>					
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the assistance of a physician. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12175.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT EDWARD FIELDS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 24 1996</b>		3. TIME OF DEATH <b>02:52 M</b>	
4. SOCIAL SECURITY NUMBER <b>214-26-9691</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 19, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4304 Spencer Street</b>	
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Aug '41 - Aug '45</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor Leader</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James A. Fields</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Tabbs</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marion E. Fields</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4304 Spencer Street Baltimore, Maryland 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park Apr 29</b>		20c. LOCATION — City or Town, State <b>Baltimore County MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert R. Terry</b>	
22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>Hypotension</b> b. <b>Pulmonary Embolus</b> c. <b>G.I. Bleeding</b> d. <b></b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Gastric ulcer</b> <b>Non-Hodgkin's Lymphoma</b>  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mohammad Saleem ER Consultant</b>				29c. LICENSE NUMBER <b>D40610</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MUHAMMAD SALEEM ST. AGNES ER</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10+1



96-2218-021

ML

ITEMS: 23 PART I, 27, PER MED

FILM G-735 5/15/96 t.t

Amended item #17, g-734, 4/26/96eh per fh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12176

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARCHIBALD E. GODWIN, Jr.</b>						2. Date of Death Month Day Year <b>APRIL 23 1996</b>			3. Time of Death <b>10:37PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>FREDERICK</b>			4c. County of Death <b>FREDERICK</b>	
Funeral Director	5. Social Security Number <b>403-46-6715</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>06/07/1937</b>
	9. Birthplace (State or Foreign Country) <b>KY</b>										
Usual Residence of Decedent											
10a. State <b>KY</b>		10b. County <b>Clark</b>		10c. City, Town or Location <b>Winchester</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1704 Pilot View Rd.</b>						10f. Zip Code <b>40391</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>						18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronic Technician</b>			18b. Kind of Business/Industry <b>Electronics</b>		
17. Father's Name <b>Archibald Archie E. Godwin, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Tabie Fletcher</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mary Lou Godwin /Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1704 Pilot View Rd. Winchester, KY 40391</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Winchester Cemetery</b>				Date <b>4/27</b>		20c. Location - City or Town, State <b>Winchester, KY.</b>	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD 21228</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC HYPERTROPHY</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>APRIL 24, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
ExaminerState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12177

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jefferson Hockensmith</i>			2. Date of Death Month <i>April</i> Day <i>20</i> Year <i>1996</i> Time <i>2:05 PM</i>		3. Time of Death	
	4a. Facility Name (If not institution, give street and number) <i>Levindale Geriatric/Rehabilitation Center</i>			4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>213-05-9151</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>89</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>August 5, 1906</i>
	9. Birthplace (State or Foreign Country) <i>Fulton Co., Pa.</i>						
Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Owings Mills</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>12415 Timber Grove Road</i>				10f. Zip Code <i>21117</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>W.W. II.</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-12-</i> College (1-4 or 5+) <i>-0-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Bus Driver-Baltimore Transit</i>		16b. Kind of Business/Industry <i>Transportation</i>	
17. Father's Name (First, Middle, Last) <i>Leonard J. Hockensmith</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Susan Mellott</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Karole S. Barton</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>H.C. 2 Box #145 / Wells Tannery, Pa. 16691</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Carroll Cremation</i>		Date <i>4-25-1996</i>		20c. Location - City or Town, State <i>Hampstead, Maryland</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Eline Funeral Home 11824 Reisterstown Road Reisterstown, Md. 21136</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>acute Cardio-pulmonary arrest</i> Due to (or as a consequence of): b. <i>atherosclerotic heart disease</i> Due to (or as a consequence of): c. <i>respiratory insufficiency / chronic obstructive pulmonary disease</i> Due to (or as a consequence of): d. <i>chronic aspiration</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>decubitus (sacral) dementia dysphagia</i> <i>5/10 Bilob above the knee amputation</i> <i>peripheral vascular disease</i> <i>5/10 Jejunostomy/gastrostomy tube</i>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Consuelo Alvarez</i>				29c. License number <i>D:44907</i>		29d. Date signed (Month, Day, Year) <i>April 22nd 1996</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>2434 W. Belvidere Ave Balto, MD 21215</i>							
31. Date filed (Month, Day, Year) <i>APR 26 1996</i>				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12178

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUIS FRANCIS HEBRON JR.</b>				2. Date of Death Month <b>APRIL</b> Day <b>20</b> Year <b>1996</b>		3. Time of Death <b>1:25 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>MERCY HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-02-1857</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>27</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 7 1968</b>	
	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6717 Foxmeadow Road</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telemarketer</b>		16b. Kind of Business/Industry <b>Eastern Communications</b>				
17. Father's Name (First, Middle, Last) <b>Louis F. Hebron Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Frances Hebron Mills</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sylvia F. Mills Hebron/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6717 Foxmeadow Rd, Baltimore Maryland 21207</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		Date <b>4-25-96</b>		20c. Location - City or Town, State <b>WOODLAWN, MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death <b>UNKNOWN</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1

1992

1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12179

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>CHARLIE Luther JOHNSON</b>				2. Date of Death Month <b>April</b> Day <b>23</b> , Year <b>1996</b>		3. Time of Death <b>15:00 p</b>	
	4e. Facility Name (If not institution, give street end number) <b>2541 Robb Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>231-42-3413</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 3, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>							
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent							
	10a. State <b>MD</b>		10b. County <b>na</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>2541 ROBB STREET</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6<sup>th</sup></b> College (1-4or 5+) <b>-</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECURITY</b>		16b. Kind of Business/Industry <b>various places</b>	
	17. Father's Name (First, Middle, Last) <b>LUTHER JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAE JOHNSON</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>RITA HARRISON</b>				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <b>2541 ROBB STREET, BALTIMORE, MD 21218</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		Date <b>4-26</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Squamous Cell Cancer of Lung 13 Months</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>		
						24e. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>D46118</b>		29d. Date signed (Month, Day, Year) <b>April 24, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3333 N. Calvert St Suite 107 Balto MD 21218</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b> 								

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edith Mae Janowiak</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 19 1996</b>		3. TIME OF DEATH <b>6:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219 34 7801</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 23, 1937</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>FALLSTON GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FALLSTON</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>ABINGDON</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>207 C OAK LEAF CIRCLE</b>			
10f. ZIP CODE <b>21009</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12YRS</b> College (1-4 or 5+) <b>WATRESS</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>WATRESS</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WILLIAMSBURG INN</b>	
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES Bowen, SR</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOSEPH J. Janowiak</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21009 207 C OAK LEAF CIRCLE ABINGDON, MARYLAND</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HIGHVIEW MEMORIAL 4-23-96</b>		20c. LOCATION — City or Town, State <b>FALLSTON, MARYLAND</b>		22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL-BURIAL, P.A. 3 NEWPORT DRIVE FOREST HILL, MD 21050</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL-BURIAL, P.A. 3 NEWPORT DRIVE FOREST HILL, MD 21050</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA of LUNG</b> Approximate Interval Between Onset and Death <b>18 MONTHS</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D31775</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 19, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOAN F. EDWARDS M.D. 212 BELAIR ROAD FALLSTON, MARYLAND 21047</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b> <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12181

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN D. KELLY, SR.</b>				2. Date of Death Month <b>April</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>9:00 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>212-86-5600</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>30</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 9, 1965</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2220 E. NORTH AVENUE</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH</b> College (14 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CONSTRUCTION WORKER</b>			16b. Kind of Business/Industry <b>CONSTRUCTION CO.</b>			
	17. Father's Name (First, Middle, Last) <b>WILLIAM KELLY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DELORES COOK</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>CLAUDE STREET/BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8391 MOVEN RD. BALTIMORE, MD. 21234</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PK.</b>		Data <b>4/23</b>		20c. Location - City or Town, State <b>ARBUTUS, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BETTS FUNERAL HOME</b> <b>1129 N. CAROLINE ST. BALTO., MD. 21213</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Progressive Multifocal Leukoencephalopathy</b> Due to (or as a consequence of): <b>b. AIDS</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>3 wks.</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number <b>P09726</b>		29d. Date signed (Month, Day, Year) <b>4/17/96</b>			
State Registrar	30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>M BATTLE 22 S GREEN ST BALTO MD 21201</b>									
	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12182

## Certificate of Death


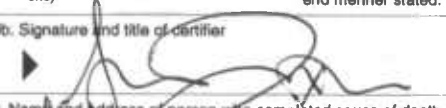
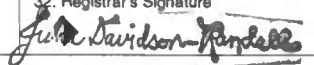
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minna Korotin					2. Date of Death Month Day Year April 21, 1996		3. Time of Death 12:30am		
	4a. Facility Name (If not institution, give street and number) Manor Care Potomac					4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 063 05 6654		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Aug. 10, 1899		9. Birthplace (State or Foreign Country) Russia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 10714 Potomac Tennis Lane				10f. Zip Code 20854		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) Barnet Korotin					18. Mother's Name (First, Middle, Maiden Surname) Sarah Beliz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Herbert Kaminsky/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9924 Grayson Avenue, Silver Spring, MD 20901					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem. Gdns		Date 4/22/96		20c. Location - City or Town, State Falls Church Virginia			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ives-Pearson Funeral Homes Falls Church VA 22201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION ACUTE Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE INDEF Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FRACTURED HIP RIGHT									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FEB 11 96		28b. Time of Injury 5:30AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Found on Floor	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NURSING HOME				28f. Location (Street and Number or Rural Route Number, City or Town, State) #4			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 007099		29d. Date signed (Month, Day, Year) APRIL 22 96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS C MAYHE 1015 FERNWOOD RD BETHESDA MD 20817									
31. Date filed (Month, Day, Year) APR 26 1996										



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOMINIC L. LAND				2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 11:45 AM			
	4a. Facility Name (If not institution, give street and number) 5000 BLK FRANKLINTOWN ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
Funeral Director	5. Social Security Number 244-90-2108		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 19 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 1, 1977	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1910 N. EUTAW PLACE				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) STEVEN JOHNSON				18. Mother's Name (First, Middle, Maiden Surname) LEAH V. LAND					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ESPERANZA SUTTON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3508 COPLEY RD, BALT, MD, 21215					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		Date 4/27/96		20c. Location - City or Town, State LANSDOWNE MD,			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Funeral Home GARY E. HATCH Funeral Home P.A. 270 FRED ABLETON PARK BALT, MD, 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Gunshot wounds of chest and abdomen Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) UNK		28b. Time of Injury UNK M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT SHOT		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PARK		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5000 BLK FRANKLINTOWN RD. City								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 21, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Davidson-Randall 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) APR 26 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 12184

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VINCENT J. LEVICKAS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>24</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-01-4574</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/13/1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS EXTENDED CARE FACILITY</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ELLCOTT CITY</b>		9c. COUNTY OF DEATH <b>HOWARD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City (Arbutus)</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4625 Wilkens Avenue</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <b>High School (12)</b> College (1-4 or 5+) <b>—</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DRAFTSMAN</b>		15b. KIND OF BUSINESS/INDUSTRY <b>STEEL MFG.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Levickas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maria —</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Herbert J. Levickas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6622 Kilmarnock Drive Baltimore, Md. 21228</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>4/27</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>M. J. [Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive heart failure due to arteriosclerotic CVD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Post myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. —</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d. —</b>							Approximate interval between Onset and Death <b>1 month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Interstitial pneumonitis</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Herbert J. Levickas M.D.</b>				29c. LICENSE NUMBER <b>D15958</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. HERBERT J. LEVICKAS - 5404 EAST DRIVE - ARBUTUS, MD 21227</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12186

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY

MAE

LINSENMEYER

2. Date of Death

Month Day Year

April 25 96

3. Time of Death

10:25 A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice- Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-20-1641

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 9, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3611 Keswick Road

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Property Officer-Clerical

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edward Linsenmeyer

18. Mother's Name (First, Middle, Maiden Summa)

Orbie Wickens

19a. Informant's Name/Relationship (Type, Print)

Ronald Robey (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Blue Bell Court, Port Deposit, Md 21904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cem

Date

4/26/96

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Md 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG METASTASES

Due to (or as a consequence of):

b. COLON CANCER

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

5 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hendall Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

4/25/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HR Faulkner / 2300 Dlang Valley Rd / Balto MD 21204

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

Hendall Faulkner

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

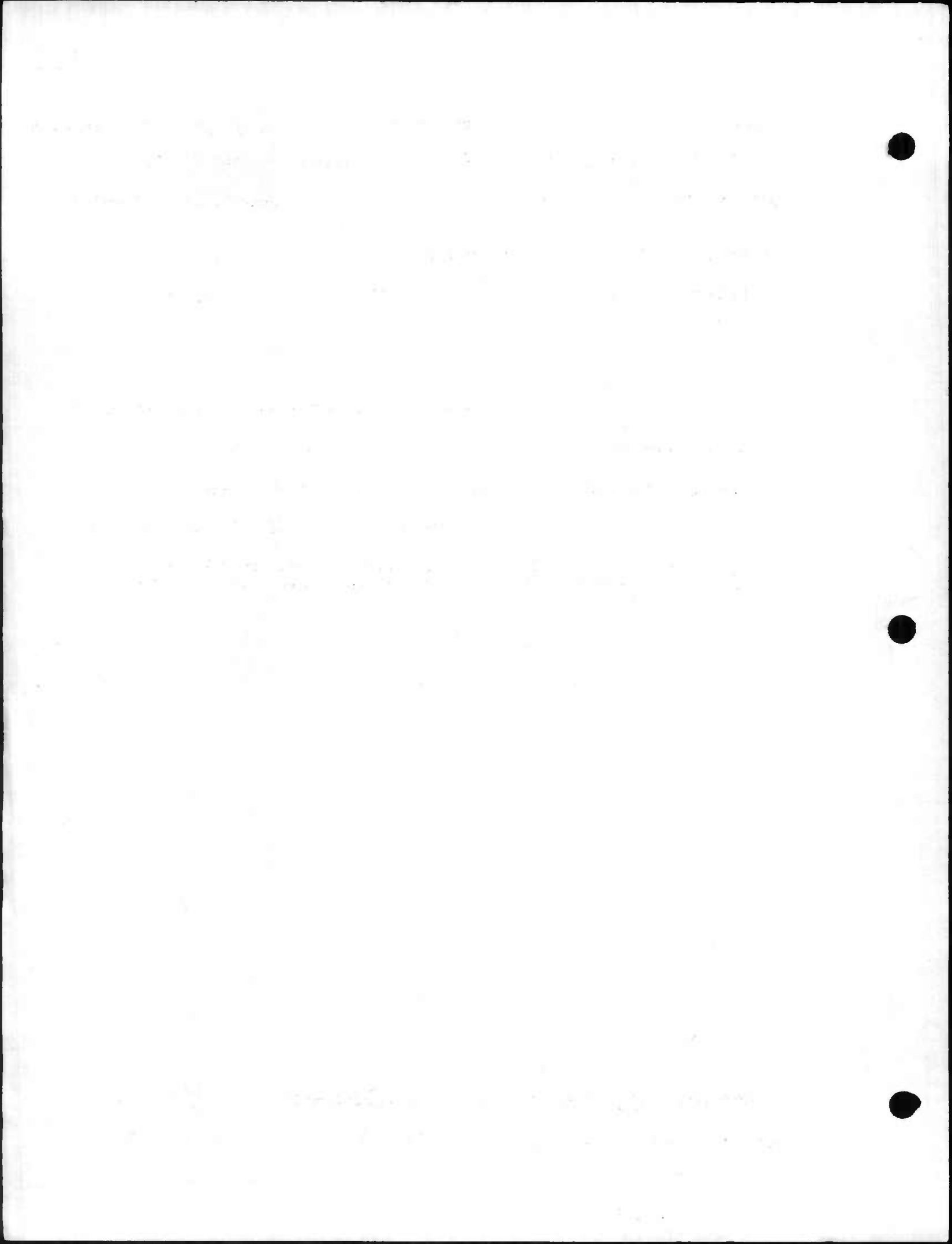
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12185

## Certificate of Death

Reg. No.

item#17 film g734 4/26/96 ag perFH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VERNELLE V. LIVINGSTON</b>		2. Date of Death Month <b>APRIL</b> Day <b>23</b> Year <b>96</b>		3. Time of Death <b>9 am</b>
	4a. Facility Name (If not institution, give street and number) <b>CHURCH HOSPITAL BALTIMORE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>n/a</b>
Funeral Director	5. Social Security Number <b>216-58-2025</b>	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>43</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) <b>OCT. 27, 1952</b>		9. Birthplace (State or Foreign Country) <b>FLORIDA</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>514 CATHEDRAL STRET</b>		10f. Zip Code <b>21201</b>	
10g. Citizen of What Country? <b>UNITED STATES</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>-</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>various trades</b>			
17. Father's Name (First, Middle, Last) <b>EDWARD LIVINGSTON EDWARD LIVINGSTON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>SHIRLEY WHITE (HOLMES)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>EDWARD LIVINGSTON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>960 N. CHAPEL ST., BALTIMORE, MD 21205</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. Location - City or Town, State <b>4-27-96 RANDALLSTOWN, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b>					
<b>c. Due to (or as a consequence of):</b>					
<b>d. Due to (or as a consequence of):</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>D.I.C., CIRRHOSIS</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D 21338</b>		29d. Date signed (Month, Day, Year) <b>4/23/1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALAN SUBASMAN: CHURCH HOSPITAL, Balto. MD</b>					
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1

State  
Registrar

Z



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12187

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Samuel Joseph Liberto</b>						2. Date of Death Month <b>April</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>11:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>5 Brett Court</b>						4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-20-5646</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 28, 1915</b>		9. Birthplace (State or Foreign Country) <b>Mississippi</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5 Brett Court</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>7th</b> Elementary/Secondary (0-12)      College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>self-employed</b>			16b. Kind of Business/Industry <b>Produce</b>			
17. Father's Name (First, Middle, Last) <b>Charles Liberto</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Mary Cascio</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Richard Liberto</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2824 Montebello Terrace Baltimore MD. 21214</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Schwartz Cemetery</b>			Date <b>4/27/96</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)			a. <b>ARRHYTHMIA DUE TO ARTERIOSCLEROTIC HEART DISEASE</b> <b>15 min.</b>							
			b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>10 yrs.</b>							
			c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>20 yrs.</b>							
			d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 				29c. License number <b>D17728</b>		29d. Date signed (Month, Day, Year) <b>April 26, 1996</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236</b>										
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Filing, 734, item #26, 4/26/96, Cyw, per DR.

State of Maryland / Department of Health and Mental Hygiene

96 12188

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward Moll</b>		2. Date of Death Month <b>Apr</b> Day <b>19</b> Year <b>96</b>		3. Time of Death <b>2112</b>
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Gen. Hosp.</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>AA</b>
Funeral Director	5. Social Security Number <b>001-22-4351</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jul 1 31</b>		9. Birthplace (State or Foreign Country) <b>N.H.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Md</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>3 Waveland Farm Road</b>		10f. Zip Code <b>21401</b>	10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>53-55</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>			
To Be Completed by Physician/Medical Examiner	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Graphic Artist</b>		16b. Kind of Business/Industry <b>Self Employed</b>		
	17. Father's Name (First, Middle, Last) <b>Fred Moll</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marjorie Ralph</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Lucille G. Graham</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Waveland Farm Rd., Annapolis, Md 21401</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>Baltimore Md</b>
21. Signature of Funeral/Service Licensee <b>Balch J. Arnold</b>		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) e. <b>Acute Cardiac Arrhythmia</b> <b>UNK</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>William P. Jones, MD Deputy</b>		29c. License number <b>D 06054</b>		29d. Date signed (Month, Day, Year) <b>4/20/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>					
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



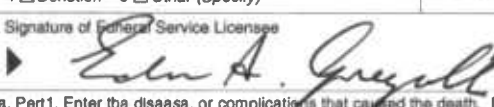
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12189

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary E. Matthews</b>				2. Date of Death Month <b>Apr.</b> Day <b>24</b> Year <b>1996</b>		3. Time of Death <b>10:50 A.M.</b>	
	4e. Facility Name (If not Institution, give street and number) <b>2623 Liberty Pkwy.</b>				4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>183-05-8437</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08/28/1905</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10e. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Edwin V. Shelly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cordie Fillmore</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Gordon Thomas/Son-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Barnaby Court Timonium, MD. 21093</b>			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Craley Cemetery</b>		Date <b>4/26</b>		20c. Location - City or Town, State <b>York, PA.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Arrhythmia</b> Due to (or as a consequence of): b. <b>HTN</b> Due to (or as a consequence of): c. <b>Hx of CVA.</b> Due to (or as a consequence of): d. <b>Hypertensive heart disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>4 yrs</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D44793</b>		29d. Date signed (Month, Day, Year) <b>4-24-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali Sanai, M.D. 6730 Holabird Ave. Balto. Md. 21222</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

12190

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALTA MAE MATHEWS

2. Date of Death

22  
Month Day Year  
APRIL 20, 1996

3. Time of Death

10<sup>30</sup> AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

6915 CHAMBERS ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

235-22-3663

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 26, 1925

9. Birthplace (State or Foreign Country)

WEST VA.

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6915 CHAMBERS ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

AT HOME

16b. Kind of Business/Industry

HOUSEWIFE

17. Father's Name (First, Middle, Last)

OSCAR DONALD CROSS

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE LAOLS

19a. Informant's Name/Relationship (Type, Print)

JOSEPH E. MATHEWS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6915 CHAMBERS ROAD BALTIMORE MARYLAND 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORRILL MEMORIAL PARK

Date

APRIL 20TH

20c. Location - City or Town, State

PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIALS  
3800 HARFORD ROAD - PARKVILLE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY ARREST

Approximate Interval Between Onset and Death

ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC RENAL CARCINOMA

CHRONIC

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

025733

29d. Date signed (Month, Day, Year)

4/25/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUNCAN SALMON MD 5601 Loch Raven Blvd Balt. MD

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

[Signature]

21239

State  
Registrar

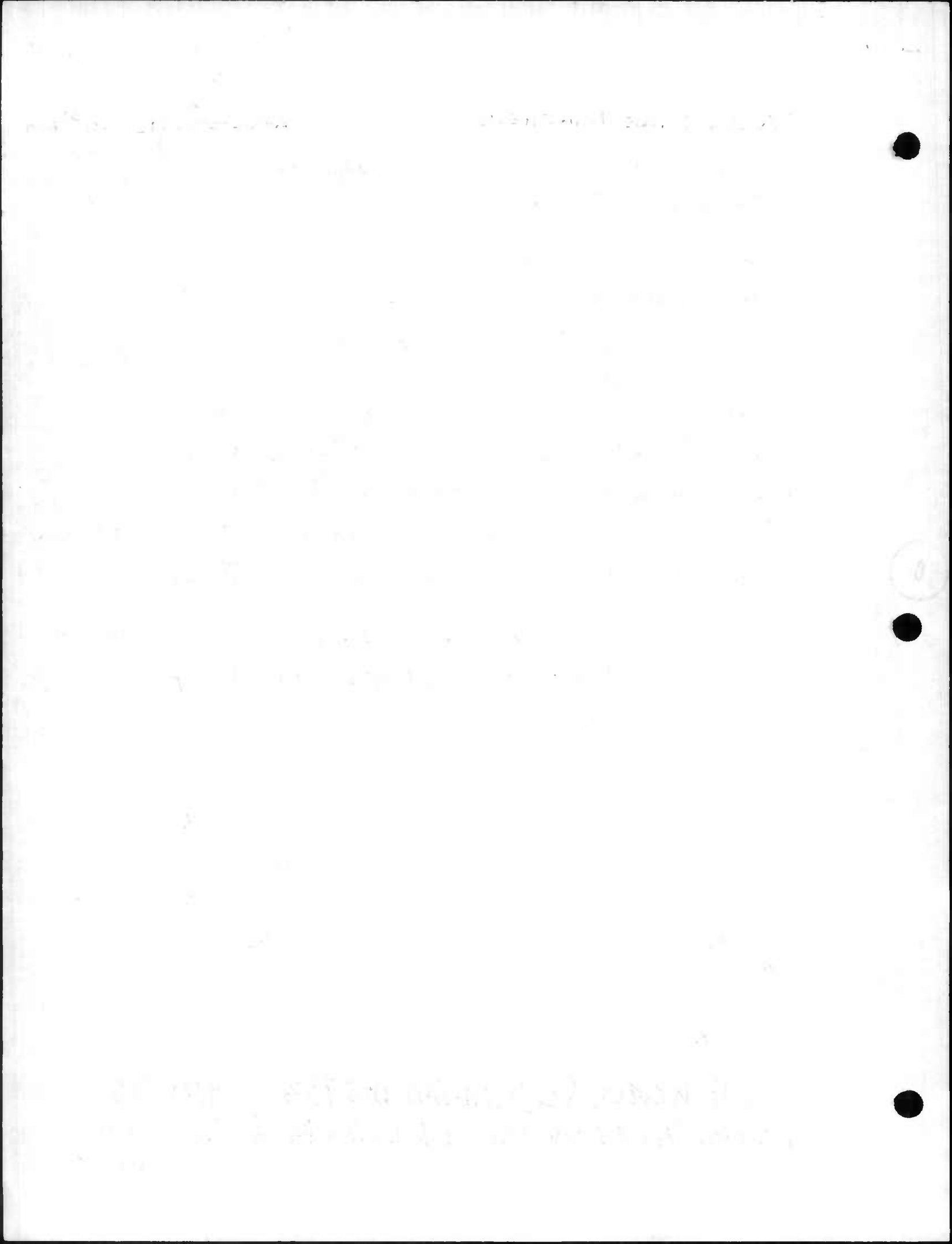
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12191

Filmg, 734, item #3, 24a, 4/26/96, cyw, fh

1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernadine Ruth Myers</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>96</b>		3. TIME OF DEATH <b>5:35 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>232-72-0834</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-22-1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Cuppett Weeks Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV.</b>		10b. COUNTY <b>Tucker</b>		10c. CITY, TOWN OR LOCATION <b>Thomas</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE <b>26292</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lemuel Helmick</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Agatha Griffith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth Knotts</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1358 Crellin Underwood Rd. Oakland, Md. 21550</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Davis Cemetery 3-12-1996 Davis, WV.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hinkle Funeral Home, Inc. P.O. Box 186 Davis, WV. 26260</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>dilated cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>ASHD</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes mellitus</b> <b>renal failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D05333</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/4/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12192

DHHM 16 Rev 6/95

SLI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

98-12193

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

2. Date of Death

April 18, 1996

3. Time of Death

3:48 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

211-27-7499

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 1, 1930

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10905 Dresden Drive

10f. Zip Code

20705

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
unknownCollege (1-4 or 5+)  
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

18b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown Unknown

19a. Informant's Name/Relationship (Type, Print)

Connie Schultz/Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10905 Dresden Drive-Beltsville, Maryland 20705

20a. Method of Disposition

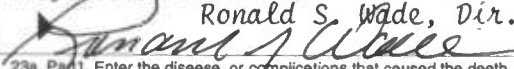
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) State perm.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street  
Baltimore, Maryland 21201-1559

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Generalized Atherosclerotic Cardio-Vascular Disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, previous Cerebrovascular Accidents,

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

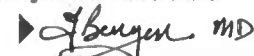
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 25925

29d. Date signed (Month, Day, Year)

April 19, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814

31. Date filed (Month, Day, Year)

APR 28 1996



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98 12194

State of Maryland / Department of Health and Mental Hygiene

Item: 12 per F.H. G-735 5/2/96 reb **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack Hewitt Morgan Sr.</b>				2. Date of Death Month <b>April</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>11:17am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>214-32-9324</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 7, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Edgewater</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>901 Mayo Road</b>		10f. Zip Code <b>21037</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1954-56</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Korean</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>Officer</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Officer</b>		16b. Kind of Business/Industry <b>AA Co. Fire Dept.</b>			
	17. Father's Name (First, Middle, Last) <b>Leonard Morgan</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Margaret Alma Hewitt</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Maria C. Morgan</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>901 Mayo Road, Edgewater, MD 21037</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		Date <b>4/29</b>		20c. Location - City or Town, State <b>Davidsonville, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Ventricular Fibrillation</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes m</b> <b>Hypertension</b>						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>22557</b>		29d. Date signed (Month, Day, Year) <b>4-25-96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>139 Old Dominion Ln. RD, Davidsonville, MD</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

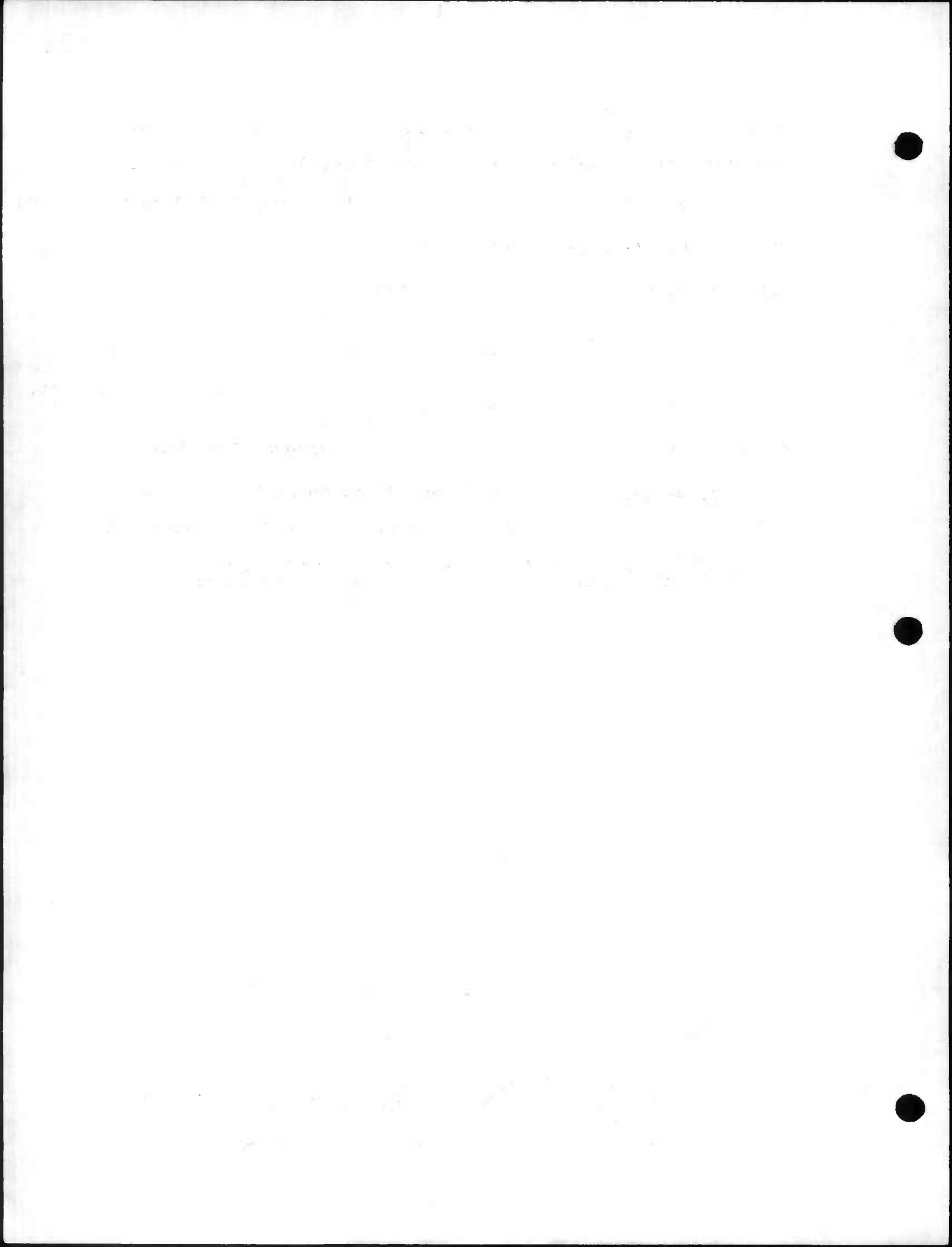
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12195

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARTIN F. MOONEY</b>		2. Date of Death Month Day Year <b>APRIL 24, 1996</b>		3. Time of Death <b>7:00 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>202 Linhigh Avenue</b>		4b. City, Town, or Location of Death <b>Fullerton</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>217-16-7046</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEBRUARY 27, 1923</b>		9. Birthplace (State or Foreign Country) <b>BALTIMORE CITY, MD.</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Fullerton - Baltimore County</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>202 Linhigh Avenue</b>		10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRINTER</b>		16b. Kind of Business/Industry <b>U.S. GOVERNMENT PRINTING OFFICE</b>
	17. Father's Name (First, Middle, Last) <b>JOHN JOSEPH MOONEY</b>		18. Mother's Name (First, Middle, Maiden Sumama) <b>MARGARET SCHMITT</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>KAREN FRIEDLANDER (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11400 MARBROOK ROAD OWINGS MILLS, MARYLAND 21117</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH CEMETERY APRIL 27, 1996</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D21022</b>	29d. Date signed (Month, Day, Year) <b>4-25-96</b>
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>M. KAWACENSIC 8604 HARTFORD RD BALTO MD 21234</b>					
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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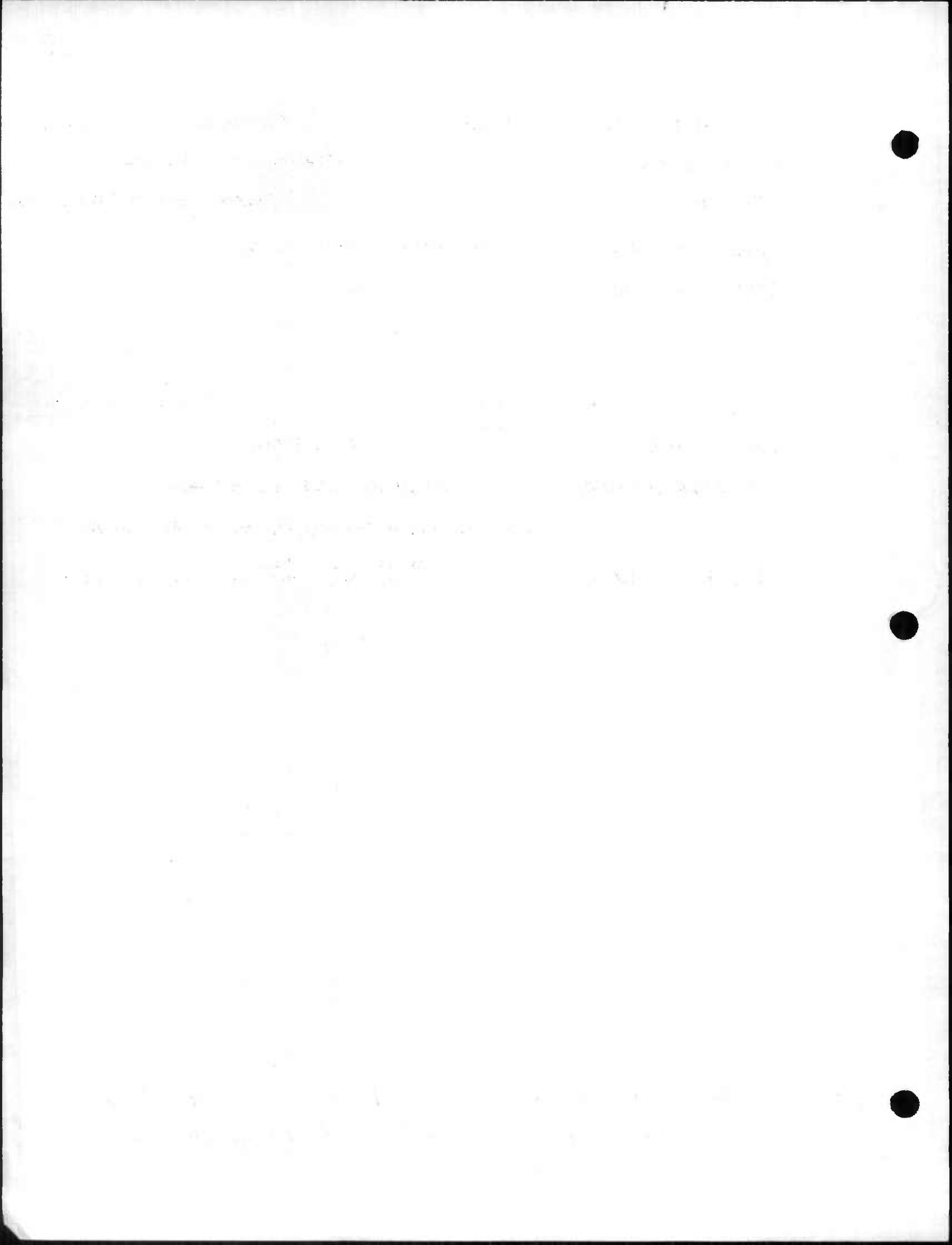
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 12196

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY MERKEL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>23</b> YEAR <b>1996</b>				3. TIME OF DEATH <b>10:49 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>197-09-6778</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>6-30-15</b>				8. BIRTHPLACE (State or Foreign Country) <b>Phila. Pa.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>Baltimore City</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>611 E. 33rd. St.</b>				10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 yrs.</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking—Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Fullerton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Medora Welch</b>					
19a. INFORMANT'S NAME (Type/Print) <b>James F. Merkel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>52 Cooper-Tomlinson Rd. Medford, N. J. 08055</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Hills Cemetery 4-26-96</b>				20c. LOCATION — City or Town, State <b>Phila. Penna.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Heather Lassahn</b>				22. NAME AND ADDRESS OF FACILITY <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. LUNG ABSCESS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>								Approximate Interval Between Onset and Death <b>1 MONTHS</b> <b>6 MONTHS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Natalia Southernland MD RESIDENT YEAR 1</b>				29c. LICENSE NUMBER <b>AT2438946</b>				29d. DATE SIGNED (Month, Day, Year) <b>APRIL 23, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATALIA SOUTHERNLAND UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND 21218</b>									
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12197

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCIS MARTIN PRETO</b>						2. Date of Death Month Day Year <b>APRIL 22, 1996</b>		3. Time of Death <b>12:30PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>						4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>137-05-5532</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 21, 1915</b>		9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>PARKVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3301 Garnet Rd.</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF EMPLOYED</b>			16b. Kind of Business/Industry <b>DIAMOND CAB</b>			
17. Father's Name (First, Middle, Last) <b>JOHN MARTIN PRETO</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>GEORGETTE BRINDISI</b>				
19a. Informant's Name/Relationship (Type, Print) <b>FRIEDA M. PRETO / spouse</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3301 GARNET Rd. BALTO. MD. 21234</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MORELAND MEMORIAL PARK</b>		Date <b>April 26 1996</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>		
21. Signature of Funeral Service Licensee <b>Charles F. Evans</b>				22. Name and Address of Facility <b>EVANS CHAPEL &amp; MEMORIALS 8800 HARFORD Rd. Balto. Md. 21234</b>						
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Congestive cardiomyopathy 5 yrs.</b> Due to (or as a consequence of): <b>Secondary to long standing ischemic 10 yrs.</b> Due to (or as a consequence of): <b>and history of myocardial infarct 8 yrs.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>1. HBP 14 yrs; Chronic Atrial Fibrillation; 2. CVA's (Cerebral infarcts); 3. Abt. Aortic Aneurysm stroke</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1. HBP 14 yrs; Chronic Atrial Fibrillation; 2. CVA's (Cerebral infarcts); 3. Abt. Aortic Aneurysm stroke</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Michael Kyle</b>								
29c. License number <b>D27693</b>		29d. Date signed (Month, Day, Year) <b>4/23/96</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL KYLE FRANKLIN SQUARE DR.</b>										
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <b>Julia Davidson-Rendell</b>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 9055.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

1. The first part of the document is a list of names and addresses.

2. The second part is a list of names and addresses.

3. The third part is a list of names and addresses.

4. The fourth part is a list of names and addresses.

5. The fifth part is a list of names and addresses.

6. The sixth part is a list of names and addresses.

7. The seventh part is a list of names and addresses.

8. The eighth part is a list of names and addresses.

9. The ninth part is a list of names and addresses.

10. The tenth part is a list of names and addresses.

11. The eleventh part is a list of names and addresses.

12. The twelfth part is a list of names and addresses.

13. The thirteenth part is a list of names and addresses.

14. The fourteenth part is a list of names and addresses.

15. The fifteenth part is a list of names and addresses.

16. The sixteenth part is a list of names and addresses.

17. The seventeenth part is a list of names and addresses.

18. The eighteenth part is a list of names and addresses.

19. The nineteenth part is a list of names and addresses.

20. The twentieth part is a list of names and addresses.

21. The twenty-first part is a list of names and addresses.

22. The twenty-second part is a list of names and addresses.

23. The twenty-third part is a list of names and addresses.

24. The twenty-fourth part is a list of names and addresses.

25. The twenty-fifth part is a list of names and addresses.

26. The twenty-sixth part is a list of names and addresses.

27. The twenty-seventh part is a list of names and addresses.

28. The twenty-eighth part is a list of names and addresses.

29. The twenty-ninth part is a list of names and addresses.

30. The thirtieth part is a list of names and addresses.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JONG SEO PARK</b>						2. Date of Death Month Day Year <b>APRIL 21, 1996</b>		3. Time of Death <b>1508PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL SHOCK TRAUMA</b>						4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>				
Funeral Director	5. Social Security Number <b>447-85-1266</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>28</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 9, 1968</b>		9. Birthplace (State or Foreign Country) <b>SEOUL, KOREA</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PERRY HALL</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3815 EAST JOPPA ROAD A-1</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>SOUTH KOREA</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>KOREAN</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES CLERK</b>			16b. Kind of Business/Industry <b>SUPER MARKET</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>SUNG DAL PARK</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>CHUN JA KIM</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>JAE SEO PARK</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21236</b> <b>3815 EAST JOPPA ROAD A-1 PERRY HALL, MARYLAND</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		Date <b>APR 25 1996</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL - BELAIR, P.A.</b> <b>3 NEWPORT DRIVE FOREST HILL, MARYLAND</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Gun shot wound of chest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>4-21-96</b>		28b. Time of Injury <b>14 43M</b>		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Food Market</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1729 W. LANE ST BALTIMORE</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 22, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12199

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN EDWARD RYAN				2. Date of Death Day Month Year APRIL 23, 1996		3. Time of Death 3:00AM	
	4a. Facility Name (If not institution, give street and number) 1309 PARKMAN AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 182-18-3768		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV 28, 1922	
	9. Birthplace (State or Foreign Country) PENNSYLVANIA							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County BALTIMORE CITY		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 1309 PARKMAN AVENUE				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry FREIGHT HAULING			
	17. Father's Name (First, Middle, Last) JOHN W. RYAN				18. Mother's Name (First, Middle, Maiden Surname) ANNA WILKINS			
	19a. Informant's Name/Relationship (Type, Print) TERRANCE RYAN (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4245 LEVICK STREET - PHILADELPHIA, PA. 19135			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Data 4/26/96		20c. Location - City or Town, State BALTIMORE	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MARYLAND 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. INOPERABLE CA OF LUNG WITH METASTASES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D01417		29d. Date signed (Month, Day, Year) 4/25/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILMER K. GALLAGER - 3455 WILKENS AVENUE - SUITE 300 - BALTIMORE, MD 21229								
31. Date filed (Month, Day, Year) APR 26 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

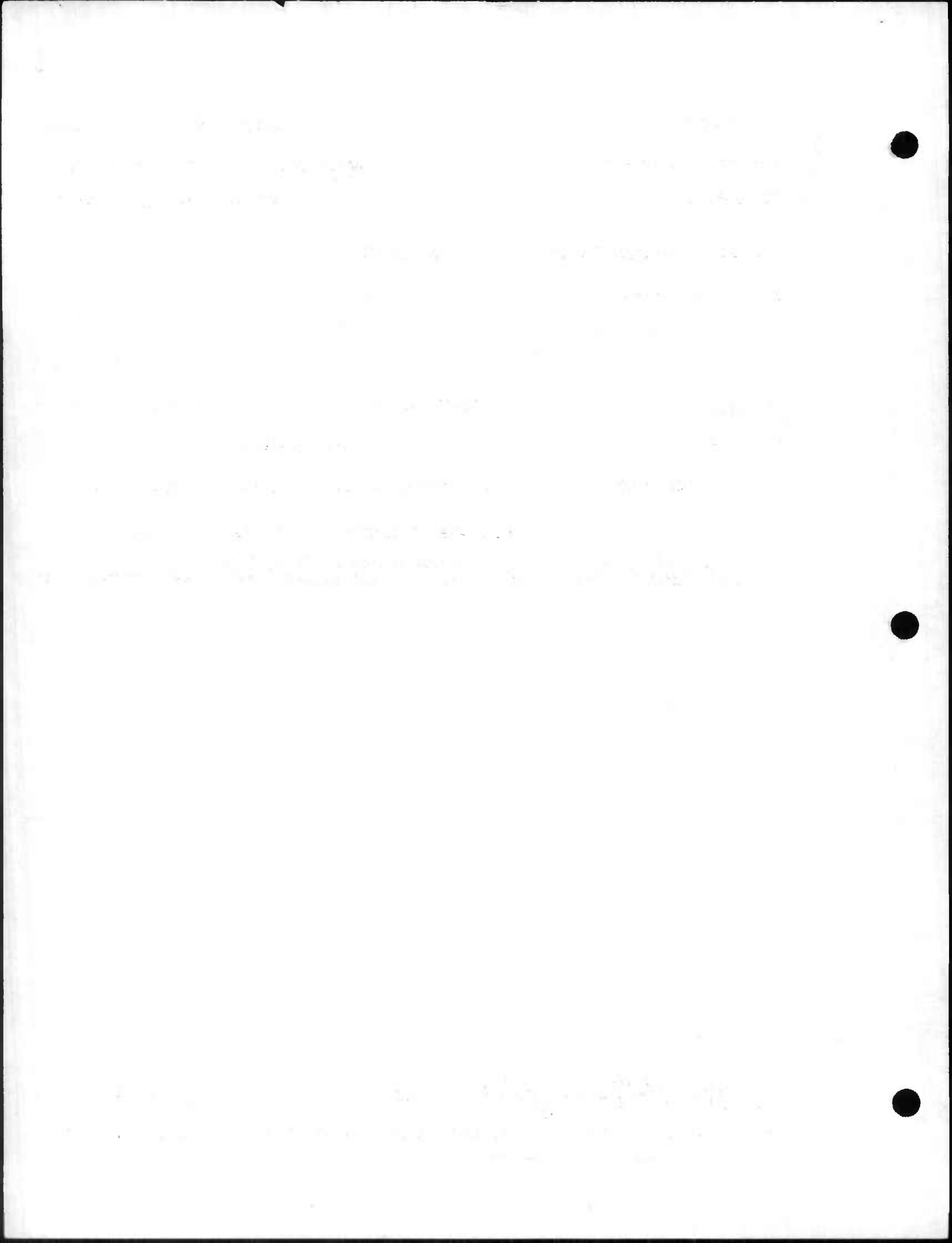
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

T+1



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVON Ricks</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>17</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>6 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219620834</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>41</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/26/55</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Allegis Health &amp; Rehab</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>1217 W. Fayette St</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>701 W. MARberry St. 21201</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>701 W. MARberry St.</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unemployed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Ricks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth PARKER EVANS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elizabeth EVANS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5339 Gist Ave Balt, Md 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Pk 4/22</b>		20c. LOCATION — City or Town, State <b>RANBALLSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Shirlette K. Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. HOLE North Ave Balt MD 2122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>UNKNOWN</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia, Seizures, Endocarditis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D16285</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-17-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PERE [Signature] 1777 Reisterstown Rd #165 Baltimore MD 21208</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12201

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carolina O. Redmond</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 24/1996</b>				3. TIME OF DEATH <b>4:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-16-3040</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 15, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Don SeCours Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4742 Fredrick Avenue</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Communications Operator</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Liberty Medical Center</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Jones</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Marion Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1530 N. Ellomont Street, Baltimore, Maryland 21217</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		DATE <b>5-19-96</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Carlton C. Dawkins</b>				22. NAME AND ADDRESS OF FACILITY <b>Douglas Funeral Service 1701 McCulloh Street, Baltimore, Maryland 21217</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b>								Approximate Interval Between Onset and Death	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Non Insulin Dependent Diabetes Mellitus</b> <b>Hypertension</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Daliah Shamsuddin MD</b>							
29c. LICENSE NUMBER <b>D20252</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/96</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DALIAH SHAMSUDDIN 20 CROSSROADS DRIVE OWINGSMILLS MD 21117</b>									
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1230318400

April

Myocardial Infarction

Myocardial Infarction



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12202

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY L. REED				2. Date of Death Month Day Year APRIL 20, 1996		3. Time of Death 11:29 AM	
	4a. Facility Name (If not institution, give street and number) SAHDY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 216-22-2191		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) MAY 26, 1927	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BEALLSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19000 BEALLSVILLE ROAD		10f. Zip Code 20839		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) EDGAR THOMPSON				18. Mother's Name (First, Middle, Maiden Surname) MARY PLUMMER			
	19a. Informant's Name/Relationship (Type, Print) HERMAN L. REED, SR. HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19000 BEALLSVILLE ROAD, BEALLSVILLE, MD. 20839			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FOREST OAK CEMETERY		Date 4/23/96		20c. Location - City or Town, State GAITHERSBURG, MD.	
	21. Signature of Funeral Service Licenses <i>Muriel H. Barber</i>				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MARYLAND 20882			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK Due to (or as a consequence of): b. Clostridium Difficile Colitis Due to (or as a consequence of): c. Gastric Outlet Obstruction Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure; Diabetes Mellitus; Renal Insufficiency							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Carl L. Schoenbays MD</i>				29c. License number D26540		29d. Date signed (Month, Day, Year) APRIL 20, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl L. Schoenbays MD 16220 Fredericks Rd., Gaithersburg							
31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature <i>John Andrew Randall</i>				



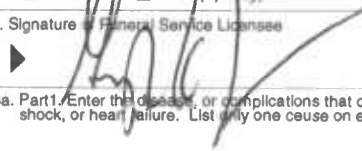

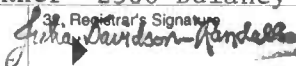
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12203

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEROY HARRY SMITH</b>				2. Date of Death Month Day Year <b>APRIL 24, 1996</b>		3. Time of Death <b>12:55am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mercy Hospital/Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-24-4817</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 12, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3915 Foster Avenue</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Baker</b>			16b. Kind of Business/Industry <b>A &amp; P</b>	
17. Father's Name (First, Middle, Last) <b>Alexander Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Webber</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Clara Ann Henson - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3915 Foster Ave., Balto., Md. 21224</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>Glen Burnie, Md.</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home of Elkridge, Inc. 5695 Main St., Elkridge, Md. 21227</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LUNG CANCER/BONE METS</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>								Approximate Interval Between Onset and Death <b>6 mos.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>4/24/96</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Kendall Faulkner 2300 Dulaney Valley Rd. Towson, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-860-0000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

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96 12204

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>DAISY V. STEELE</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>24</i> YEAR <i>96</i>		3. TIME OF DEATH <i>11:00 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>351-38-1433</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>98</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>03/20/1898</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Lorien Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard</i>	
10a. STATE <i>NY</i>				10b. COUNTY <i>Saratoga</i>		10c. CITY, TOWN OR LOCATION <i>Clifton Park</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>26 Throughbred Way</i>			
10f. ZIP CODE <i>12065</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Albert James Slade</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Louie Campbell</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Hilary H. Abbott/ Daughter</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>26 Throughbred Way, Clifton N.Y. 12065</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>		20c. LOCATION — City or Town, State <i>4/26 Beltsville, MD.</i>		20d. DATE <i>4/26</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edmund J. Grogan</i>				22. NAME AND ADDRESS OF FACILITY <i>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Balto. MD. 21222</i>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>end stage dementia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>10 yrs</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic Deep Vein Thrombosis</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pat Chagnon</i>				29c. LICENSE NUMBER <i>D322777</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/24/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>2 KNOLL ROAD DR COLUMBIA MD 21045</i>							
31. DATE FILED (Month, Day, Year) <i>APR 26 1996</i>				32. REGISTRAR'S SIGNATURE <i>John R. Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12205

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER HAWKINS SMITH</b>				2. Date of Death Month Day Year <b>APR 23 96</b>		3. Time of Death <b>8:24 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>214-38-5449</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR 27, 1942</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1320 DIVISION STREET</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH</b> College (1-4 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>			16b. Kind of Business/Industry <b>GUNTHER'S TRUCKING</b>			
	17. Father's Name (First, Middle, Last) <b>WALTER HAWKINS, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FLORENCE SMITH</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JOYCE C. SMITH/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1320 DIVISION ST. BALTIMORE, MD. 21217</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		Date <b>4/26</b>		20c. Location - City or Town, State <b>LANSDOWNE, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BETTS FUNERAL HOME</b> <b>1129 N. CAROLINE ST. BALTO., MD. 21213</b>					
	23a. Part II. Under the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LIVER METASTASES</b>  Due to (or as a consequence of): <b>PANCREATIC CANCER</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 mos ago.</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  <b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>4/25/96</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>KENDALL R. FAULKNER, MD. 2300 Julemoy Valley Rd. Towson, MD. 21204</b>									
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12206

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lilian

SHILTON

2. Date of Death

Month  
APRILDay  
19Year  
1996

3. Time of Death

5:05 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Brooke Grove Rehabilitation Center

4b. City, Town, or Location of Death

Sandy Springs

4c. County of Death

Montgomery

5. Social Security Number

129-09-9381

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 18, 1907

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1001 Spring Street, #1124

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

U.S. Information Agency

17. Father's Name (First, Middle, Last)

Jacob Rosenblatt

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Lessick

19a. Informant's Name/Relationship (Type, Print)

Peggie Odick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

51 Monroe Street, #1603, Rockville, Md. 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Mem. Gdn. 4-22

Date

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

Lisa D. Williams

22. Name and Address of Facility

Ives-Pearson Funeral Homes  
Falls Church, Va. 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INFARCTED BOWEL

Due to (or as a consequence of):

c. INTESTINAL OBSTRUCTION

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ted E. Howe

29c. License number

D33700

29d. Date signed (Month, Day, Year)

APRIL 19, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TED E. HOWE M.D. 7542 OVERLOOK DR.

BOONSBORO, MD

31. Date of Death (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



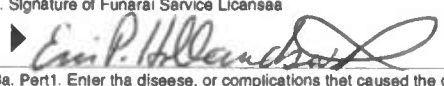
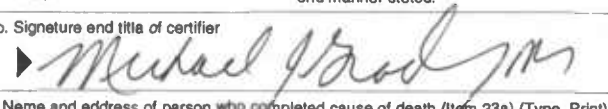
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12207

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence Schenof</b>				2. Date of Death Month <b>April</b> Day <b>12</b> Year <b>1996</b>		3. Time of Death <b>7:55pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Potomac</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>213-56-6799</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 24, 1905</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Potomac</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>10714 Potomac Tennis Ln.</b>		10f. Zip Code <b>20864</b>	
To Be Completed by Funeral Director	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Sam Cohen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ray Baddock</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Barry R. Schenof</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7419 Lynnhurst St., Chevy Chase, Md 20815</b>			
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Mem. Grdns.</b>		20c. Location - City or Town, State <b>4/14/96 Olney, Md</b>		20d. Date	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ives-Pearson Funeral Homes Falls Church, Va 22046</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure</b> Due to (or as a consequence of): <b>b. Atherosclerotic vascular disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>48°</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA (cerebrovascular accident)</b> <b>Diabetes Mellitus (Insulin)</b> <b>COPD (Chronic obstructive lung disease)</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day, Year)		27b. Time of Injury <b>M</b>		27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27d. Describe how injury occurred		27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D38781</b>		29d. Date signed (Month, Day, Year) <b>4/16/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL GRADY 4910 MASSACHUSETTS AVE WASHINGTON DC 20008</b>								
31. Date of Death (Month, Day, Year) <b>APR 26 1996</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12208

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clara Elizabeth Simpson</b>						2. Date of Death Month Day Year <b>April 23, 1996</b>		3. Time of Death <b>15:40 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Montgomery County General Hospital</b>						4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>220 01 6403</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 2, 1914</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		
	Usual Residence of Decedent						10e. State <b>Md.</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Dayton</b>
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						10f. Zip Code <b>21736</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced						12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+) <b>-</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>			
17. Father's Name (First, Middle, Last) <b>George Albert Myers</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Estelle Powell</b>					
19e. Informant's Name/Relationship (Type, Print) <b>James Hackett</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5041 Greenbridge Rd. Dayton, Md. 21736</b>					
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bushy Park Cemetery</b>		20c. Location - City or Town, State <b>Dayton, Md.</b>		20d. Date <b>4/27/96</b>	
21. Signature of Funeral Service Licensee <b>Harry W. Haight</b>						22. Name and Address of Facility <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>					
23e. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Congestive Heart failure</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>3 yrs.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <b>Rahul Gilotra MD</b>					
29c. License number <b>D32417</b>						29d. Date signed (Month, Day, Year) <b>April 24<sup>th</sup>, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAHUL GILOTRA MD 12016 GEORGIA AVENUE WHEATON MD 20902</b>						31. Date filed (Month, Day, Year) <b>APR 26 1996</b>					
32. Registrar's Signature <b>John Davidson Randall</b>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12209

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willibell THOMAS</b>				2. Date of Death Month <b>April</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>3:55 Pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>131-26-1732</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth Month <b>SEPT</b> Day <b>12</b> Year <b>1926</b>	
	9. Birthplace (State or Foreign Country) <b>S. CAROLINA</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1409 WINTER PARK CIRCLE apt.G</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th</b> College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>LAUNDRY</b>			
	17. Father's Name (First, Middle, Last) <b>WILLIE RIDGES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EILLA BELL PURCELL</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>LINDA HALL</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1203 HANDSWORTH PLACE, ESSEX, MD 21221 apt;L</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM. 4-29</b>		20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiac Event</b> Due to (or as a consequence of):  b. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypertension</b>							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>DJ92222</b>		29d. Date signed (Month, Day, Year) <b>4-24-96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kathryn Yamamoto 9000 Franklin Square Drive Baltimore Maryland 21237</b>							
	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>							
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12210

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Titus Jr</i>				2. Date of Death Month <i>April</i> Day <i>22</i> Year <i>1996</i>				3. Time of Death <i>1940 P</i>	
	4a. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N?A</b>	
Funeral Director	5. Social Security Number <i>218-84-8221</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>35</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>AUG. 26, 1960</i>		9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <i>n/a</i>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2503 VIOLET AVENUE apt.104 south</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11 th</i> College (1-4 or 5+) <i>-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DISABLED LABORER</b>				16b. Kind of Business/Industry <b>various trades</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM TITUS SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DELORES BESSICK</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>DELORES ROBINSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1010 W. BALTIMORE ST., BALTIMORE, MD 21223 apt. 805</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		Date <b>4-27</b>		20c. Location - City or Town, State <b>RANDALLSTOWN, MD</b>			
	21. Signature of Funeral Service Licensee <i>Synette K Jones</i>				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>E coli Sepsis</i> Due to (or as a consequence of): b. <i>Chronic Small Intestine Colitis</i> Due to (or as a consequence of): c. <i>Small Intestine ulcers which bleed</i> Due to (or as a consequence of): d. <i>Pneumonia so to the point that wound</i>								Approximate Interval Between Onset and Death <i>1 week</i> <i>years</i> <i>years</i> <i>year</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Enteroviral Sepsis</i> <i>Bilateral Pneumonia</i> <i>Gastrointestinal Bleeding</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>030408</i>		29d. Date signed (Month, Day, Year) <i>4/24/96</i>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Reed Robinson md 2600 Liberty Harbors Park md 21115</i>									
	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <i>[Signature]</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12211

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Cornell Thompson Jr.</i>					2. Date of Death Month <i>April</i> Day <i>22</i> Year <i>1996</i>		3. Time of Death <i>1:56 pm</i>			
	4e. Facility Name (If not institution, give street and number) <i>Sinai Hospital</i>					4b. City, Town, or Location of Death <i>Balto</i>		4c. County of Death <i>N/A</i>			
Funeral Director	5. Social Security Number <i>213-32-8512</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>57</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Aug 10, 1938</i>		9. Birthplace (State or Foreign Country) <i>N.C.</i>		
	Usual Residence of Decedent										
10e. State <i>md</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Balto</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <i>5108 Chalgrave Ave</i>				10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>10/31/55 11/27/57</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Foreman</i>			16b. Kind of Business/Industry <i>Costal steel Co.</i>				
17. Father's Name (First, Middle, Last) <i>Cornell Thompson Sr.</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Estella Duren</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Jessie B. Thompson - wife</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5108 Chalgrave Ave Balto, md 21215</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison forest vet</i>		Date <i>4/29/96</i>		20c. Location - City or Town, State <i>Owings mills, md</i>			
21. Signature of Funeral Service Licensee <i>Sharon Stokes</i>						22. Name and Address of Facility <i>March F. H. West 4300 Wabash Ave</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral Vascular Accident</i> Due to (or as a consequence of):											
b. <i>Hypertension</i> Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. <i>ATrial Fibrillation</i>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <i>A52402321GS9944</i>				29d. Date signed (Month, Day, Year) <i>April 22 1996</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Gary Schick M.D. 2401 West Belvedere Baltimore Maryland 21215</i>											
31. Date filed (Month, Day, Year) <i>APR 26 1996</i>			32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96-2140-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 16a, PER F.H. FILM G-735

State of Maryland / Department of Health and Mental Hygiene

96 12212

5/9/96 t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LARRY ARNOLD THOMAS</b>				2. Date of Death Month Day Year <b>APRIL 19, 1996</b>		3. Time of Death <b>17:20 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>5000 BLK. ERDMAN AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>unk.</b>		6. Sex <b>♂</b> <input type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>34</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 22, 1961</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1214 Sheridan</b>		10f. Zip Code <b>21239</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled UNEMPLOYED</b>				16b. Kind of Business/Industry <b>n/a</b>		17. Father's Name (First, Middle, Last) <b>Herbert Thomas Sr.</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Tillie Maness</b>				19a. Informant's Name/Relationship (Type, Print) <b>Tillie Thomas</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1214 Sheridan Balto., MD 21239</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hills</b>		20c. Location - City or Town, State <b>Essex, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>James A. Morton</i>				22. Name and Address of Facility <b>James A. Morton &amp; Sons Funeral Home 1701 Laurens St. Balto., MD 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>STREET</b>			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>4-19-96</b>			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>1705 M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how Injury occurred <b>Pedestrian struck by Auto</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>5000 blk Erdman Ave</b>			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>			
	29c. License number <b>OCME</b>				29d. Date signed (Month, Day, Year) <b>APRIL 20, 1996</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>APR 26 1996</b>			
	32. Registrar's Signature <i>[Signature]</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 1, Film 734, 4/26/96, 1t

State of Maryland / Department of Health and Mental Hygiene

96 12213

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY JANE SHOWELL TYSON</b>						2. Date of Death Month <b>APRIL</b> Day <b>24</b> Year <b>96</b>		3. Time of Death <b>11:43 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>University of Maryland Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>		
Funeral Director	5. Social Security Number <b>213-32-4915</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 3 1937</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Indiana</b>		10b. County <b>Indianapolis</b>		10c. City, Town or Location <b>Indianapolis</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>6431 Sunset Lane</b>				10f. Zip Code <b>46260</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6+</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College President</b>			16b. Kind of Business/Industry <b>Aeon Bible College</b>			
	17. Father's Name (First, Middle, Last) <b>Winfield Amos Showell</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Genevieve Frances Young</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>James Edison Tyson (husband)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6431 Sunset Lane Indianapolis, IN 46260</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Entombment</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>			Date <b>May 4</b>		20c. Location - City or Town, State <b>Baltimore County, MD</b>		
	21. Signature of Funeral Service Licensee <i>Sean A Parker</i>					22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. IDIOPATHIC PULMONARY FIBROSIS</b> Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):									Approximate Interval Between Onset and Death <b>3 YEARS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Sam Yoon MD</i>		29c. License number <b>P09767</b>		29d. Date signed (Month, Day, Year) <b>APRIL 25, '96</b>				
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>SAM YOON 22 S. GREENE ST. BALTIMORE, MD 21201</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature <i>Jason Handall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12214

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACKIE RANDALL TARBART</b>				2. Date of Death Month Day Year <b>APRIL 24, 1996</b>		3. Time of Death <b>10:35am</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-40-7645</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth <b>July 18, 1944</b> <b>April 24, 1996</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore,</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2108 Smith Avenue</b>			10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Refridgeration Mechanic</b>			16b. Kind of Business/Industry <b>Green Spring Dairy</b>		
	17. Father's Name (First, Middle, Last) <b>Joseph G. Tarbart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley Smoot</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Brenda Tarbart/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2108 Smith Avenue Baltimore, Maryland 21209</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		Date <b>4/26/96</b>		20c. Location - City or Town, State <b>Sykesville, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>A. Alan Seitz, Jr. Funeral Home</b> <b>3818 Roland Ave., Baltimore, Maryland 21211</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of): <b>b. SMALL CELL LUNG CANCER</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b> <b>HEPATIC FAILURE</b>							
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>D27730</b>		29d. Date signed (Month, Day, Year) <b>4/25/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GARY I. COLTON, MD. 6569 N. CHARLES ST. BALTO. MD 21204</b>							
	31. Date filed (Month, Day, Year) <b>APR 26 1996</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12215

ITEM#1 film g734 4/26/96ag perFH Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA WilsonWILLIAMS aka ANNIE WILSON WILLIAMS

2. Date of Death

Month Day Year  
April 24, 1996

3. Time of Death

4:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2427 HARLEM AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-16-3218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MAY 24, 1992

9. Birthplace (State or Foreign Country)

NEWPORT NEWS, VA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2427 HARLEM AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 th

College (1-4 or 5+)

-

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GENERAL SERVICES

16b. Kind of Business/Industry

SOCIAL SECURITY ADMINISTRATION

17. Father's Name (First, Middle, Last)

JOHN HENRY WILSON

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED WALKER

19a. Informant's Name/Relationship (Type, Print)

PATRICIA Y. WILLIAMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2427 HARLEM AVE., BALTIMORE, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

4-27

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March Funeral Home

1101 E. North Avenue, Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARCINOMATOUS Meningitis

Approximate Interval Between Onset and Death

2 mo

a. Due to (or as a consequence of):

CANCER OF THE OVARY

7 mo.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D37238

29d. Date signed (Month, Day, Year)

4.24.96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. J. KENNEDY, Oncology 130, Johns Hopkins Hospital, 600 N Wolfe St, Baltimore

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12216

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALLEN WEAVER Jr.</b>				2. Date of Death Month Day Year <b>APRIL 23, 1996</b>		3. Time of Death <b>1:20 a</b>								
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>n/a</b>								
Funeral Director	5. Social Security Number <b>220-34-6891</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>MAY 29, 1938</b>	9. Birthplace (State or Foreign Country) <b>GEORGIA</b>							
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number <b>5116 DARIEN ROAD</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>UNITED STATES</b>								
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION</b>								
	17. Father's Name (First, Middle, Last) <b>ALLEN WEAVER SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MINOR YOUNGBLOOD</b>										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ADDIE HENSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1754 HOMESTEAD STREET, BALTIMORE, MD 21218</b>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL PARK</b>		Date <b>4-29</b>		20c. Location - City or Town, State <b>DUNDALK, MD</b>								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
	<table border="1"> <tr> <td>a. <b>Sepsis</b> Due to (or as a consequence of):</td> <td>Approximate interval between Onset and Death <b>72 hours</b></td> </tr> <tr> <td>b. <b>Endocarditis</b> Due to (or as a consequence of):</td> <td><b>20 days</b></td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> <td></td> </tr> </table>								a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate interval between Onset and Death <b>72 hours</b>	b. <b>Endocarditis</b> Due to (or as a consequence of):	<b>20 days</b>	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):
a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate interval between Onset and Death <b>72 hours</b>														
b. <b>Endocarditis</b> Due to (or as a consequence of):	<b>20 days</b>														
c. Due to (or as a consequence of):															
d. Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier  MD				29c. License number <b>N2474</b>		29d. Date signed (Month, Day, Year) <b>April 23rd, 1996</b>									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Aberna Brewster, Johns Hopkins Hospital</b>															
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature 													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12217

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosie IRENE WATTERS				2. Date of Death Month Day Year April 19, 1996		3. Time of Death 7:32 PM	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				4b. City, Town, or Location of Death ROSBAL		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213 30 5732	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 2, 1932		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				10a. State MARYLAND		10b. County HARFORD	
To Be Completed by Funeral Director	10c. City, Town or Location FAUSTON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1315 TERRY WAY	
	10f. Zip Code 21047				10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4or 5+) 12 YRS.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AT HOME		16b. Kind of Business/Industry HOUSEWIFE	
	17. Father's Name (First, Middle, Last) JOSEPH EUGENE LUCAS				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE IRMA GRAF			
	19a. Informant's Name/Relationship (Type, Print) DANIEL E. WATTERS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 EAST MACPHERSON ROAD BELAIR, MARYLAND 21014			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) EMORY UNITED METHODIST CHURCH 1996		20c. Location - City or Town, State STREET, MARYLAND	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple traumatic injuries to head and chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death IMMEDIATE			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) APR 19 1996		28b. Time of Injury 1820 PM		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred Passenger in auto in motor vehicle accident				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) BELAIR RD AT WHOLESALE CLUB DRIVE BALTIMORE MD 21236				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier J. Crossan O'Donovan, M.D.				
29c. License number D07632				29d. Date signed (Month, Day, Year) April 20, 1996				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. CROSSAN O'DONOVAN, M.D.; 2112 DUNDALK AVE. BALTO MD 21222				31. Date filed (Month, Day, Year) APR 26 1996				
32. Registrar's Signature [Signature]				33. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12218

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DEBORAH J. WOODARD</b>				2. Date of Death Month Day Year <b>APR 21, 1996</b>		3. Time of Death <b>4 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1617 PUMPHREY STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>213-64-6868</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>43</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB 6, 1953</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number <b>1617 PUMPHREY STREET</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>2 YRS.</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>AT HOME</b>		16b. Kind of Business/Industry <b>HOUSEWIFE</b>				
	17. Father's Name (First, Middle, Last) <b>ALEXANDER S. KOSYJANA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BERNADINE L. WLAOKOWSKI</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JOHN M. KOSYJANA</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5647 LEIDEN ROAD BALTIMORE, MARYLAND 21206</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. STANISLAUS CEMETERY</b>		20c. Location - City or Town, State <b>1996 OUNDALE, MARYLAND</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVAN CHAPLAIN OF MEMORIES 8800 HARFORD ROAD - PARKVILLE, MARYLAND</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ANAPLASTIC ASTROCYTOMA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Approximate Interval Between Onset and Death <b>6.5 YEARS</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D23683</b>		29d. Date signed (Month, Day, Year) <b>APR 22, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STANITA GROSSMAN MD JOHNS HOPKINS ONCOLOGY CENTER BALTIMORE MD 21287</b>									
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

313

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Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CYNTHIA E WAINWRIGHT</b>				2. Date of Death Month <b>APRIL</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>10:00 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>				
Funeral Director	5. Social Security Number <b>217-56-3516</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>March 24, 1950</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>			10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>603 Bridgeview Rd.</b>					10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lab Assistant</b>			16b. Kind of Business/Industry <b>State of MD</b>			
17. Father's Name (First, Middle, Last) <b>Donald E. Wainwright</b>					16. Mother's Name (First, Middle, Maiden Surname) <b>Alice E. Esters</b>						
19a. Informant's Name/Relationship (Type, Print) <b>FRANCIS Wainwright</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>514 Bridgeview Rd. BALTO., MD 21225</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Calvary Cemetery</b>		Data <b>4/27</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>				
21. Signature of Funeral Service Licensee <b>James A. Morton</b>					22. Name and Address of Facility <b>James A. Morton &amp; Sons Funeral Home 1701 Laurens St. BALTO., MD 21217</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MASSIVE PULMONARY EMBOLISM</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</b> <b>MORBID OBESITY.</b>  Dua to (or as a consequence of):  Dua to (or as a consequence of):  Dua to (or as a consequence of):  Dua to (or as a consequence of):										Approximate Interval Between Onset and Death <b>1 Hour.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</b> <b>MORBID OBESITY.</b>							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29b. Signature and title of certifier <b>Dr. [Signature] PGY-I INTERN.</b>			29c. License number <b>AS 2441614-13</b>			29d. Date signed (Month, Day, Year) <b>APRIL 22 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NOREEN JORAL HARBOR HOSPITAL CTR, 3001 SOUTH HANOVER ST., BALTIMORE, MD 21225.</b>											
31. Date filed (Month, Day, Year) <b>APR 26 1996</b>			32. Registrar's Signature <b>[Signature]</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12220

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WEAVER, ALLEN</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>18</b> YEAR <b>196</b>		3. TIME OF DEATH <b>15:30</b> M	
4. SOCIAL SECURITY NUMBER <b>219-70-2476</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/17/58</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland Correctional Institution</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>unknown</b>		10b. COUNTY <b>unknown</b>		10c. CITY, TOWN OR LOCATION <b>unknown</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>unknown</b>				10f. ZIP CODE <b>unknown</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unknown</b>		16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>			
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kenya Lee (daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>In State rem.</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph B. Van Sant</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>AIDS</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>liver cirrhosis</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mohamed S. Mousa</b> MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>3/18/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mohamed S. Mousa</b> MD <b>1001 Winding Creek Way Germantown MD 20824</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1996</b>		32. REGISTRAR'S SIGNATURE <b>Jahia Davis-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12221

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <del>William R. YARBROUGH</del> William R. Yarbrough				2. Date of Death Month Day Year April 16 1996		3. Time of Death 10:06 PM	
4a. Facility Name (If not institution, give street and number) Church Home Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
5. Social Security Number 257-32-8873		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 27, 1927	
9. Birthplace (State or Foreign Country) unknown		10. Usual Residence of Decedent		11. Merit Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 18 S. Broadway				10f. Zip Code 21231		10g. Citizen of What Country? U.S.A.	
11. Merit Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown			
19a. Informant's Name/Relationship (Type, Print) Roland Yarbrough/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown, Lagrange, Georgia-unknown			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.				22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Cerebellar Injury Due to (or as a consequence of): c. Cerebrovascular Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular Disease							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier C. Borkhan MD				29c. License number D-26594		29d. Date signed (Month, Day, Year) April 16 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIAZ BOKHARI M.D. 100 N. BROADWAY BALTIMORE MD 21231							
31. Date filed (Month, Day, Year) APR 26 1996				32. Registrar's Signature John Duckworth Randall			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5056.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12222

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MILTON

ZMIJEWSKI

2. Date of Death  
Month Day Year

April

26

1996

12:02 am

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-12-0315

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

May 6, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 Lyndale Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insulation Operator

16b. Kind of Business/Industry

Western Elector

17. Father's Name (First, Middle, Last)

Stanley Zmijewski

18. Mother's Name (First, Middle, Maiden Surname)

Stella Wdziecny

19a. Informant's Name/Relationship (Type, Print)

Irene O. Zmijewski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Lyndale Avenue Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 4/29/96 Baltimore, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin Dippel

22. Name and Address of Facility

The Dippel Funeral Home Inc.

7110 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
6 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bone metastases

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kendall Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

April 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

Kendall Faulkner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



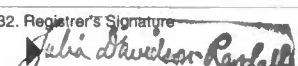
State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12223  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HILMER HARRISON ALIFF</b>						2. Date of Death Month <b>March</b> Day <b>23</b> Year <b>1996</b>		3. Time of Death <b>1840 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>						4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>236-07-0465</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 30, 1912</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent						10c. City, Town or Location <b>Mt. Airy</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>4th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Coal Miner</b>		16b. Kind of Business/Industry <b>Coal Mines</b>					
	17. Father's Name (First, Middle, Last) <b>Barney Aliff</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Wriston</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Linda Reed, sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1008 Village Oaks Drive Mt. Airy, Maryland 21771</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>High Lawn Mem. Park</b>		Date <b>3/29/96</b>		20c. Location - City or Town, State <b>Oak Hill, West Virginia</b>			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd. Mt. Airy, Maryland 21771</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COAL-WORKERS PNEUMONITIS</b> <b>FOR PULMONALE</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 										
29c. License number <b>023630</b>										
29d. Date signed (Month, Day, Year) <b>03-24-96</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANK J. MAYO MD 16220 FREDERICK RD #213, GAITHERSBURG, MD 20877</b>										
31. Date filed (Month, Day, Year) <b>MAR 25 1996</b>										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96-1956-033

ITEMS: 23 PART I, 27,

PER MED FILM G-735 5/17/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12224

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ORLANDO ANDERSON</b>				2. Date of Death Month Day Year <b>APRIL 12 1996</b>		3. Time of Death <b>5:42 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>192-62-3682</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>14</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 17, 1981</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5201 Caroline Circle</b>				10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>			16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>William Orlando Anderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sharon Denise Lightfoot</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert M. Dyson - Step-Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5201 Caroline Circle, Waldorf, Maryland 20601</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington Cemetery</b>		20c. Location - City or Town, State <b>Washington, PA</b>		
21. Signature of Funeral Service Licenses <b>Rejda C. Thornton Johnson</b> <b>REJDA C. THORNTON JOHNSON M00583</b>				22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P. A.</b> <b>#3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CARDIOMYOPATHY</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Donald G. Wright MD</b>				29c. License number <b>O.C.M.E.</b>
29d. Date signed (Month, Day, Year) <b>APRIL 13, 1996</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>				
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>				32. Registrar's Signature <b>Julia Davidson Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 505-8.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12225

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH ARMSTRONG</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>10</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>4:20 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>220-58-0033</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 21, 1903</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LIONS MANOR NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>RAWLINGS</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P. O. BOX 276</b>				10f. ZIP CODE <b>21557</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13-16 or 17+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWNER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GROCERY RETAIL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FRANK HUTSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ORA HECKERT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOHN F. ARMSTRONG, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 BARNARD PLACE FROSTBURG, MARYLAND 21532</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SUNSET MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>4/13 CUMBERLAND, MARYLAND</b>		22. NAME AND ADDRESS OF FACILITY <b>HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MARYLAND 21502</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James D. Hafner</i>				22. NAME AND ADDRESS OF FACILITY <b>HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MARYLAND 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>C.V.A. &amp; severe dysphagia</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>A.S.P.V.D.</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multiple C.V.A.s and TIAs, HYPERTENSION</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>V.A. Ranjithan M.D.</b>				29c. LICENSE NUMBER <b>D19750</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 16th 96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V.A. Ranjithan, M.D., Lions Manor N.H., Seton Dr., Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 12 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Swisher-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


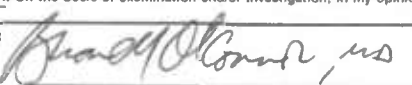

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDA BELL ANDERSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 24, 1996</b>		3. TIME OF DEATH <b>10:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>235-52-7409</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 12, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9b. COUNTY OF DEATH <b>Frederick</b>	
9c. FACILITY NAME (If not institution, give street and number) <b>809 M Stratford Dr.,</b>				10. RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>809 M Stratford Dr.,</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Oscar Riley Catlett</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nannie Pearl Sherrard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jennifer Anderson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>809 M Stratford Dr., Frederick, MD 21701</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wesley Chapel Cemetery 3/29/1996</b>		20c. LOCATION — City or Town, State <b>Frederick Co., Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA OF RECTUM</b>							<b>16 MONTHS</b>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Brian M. O'Connor, MD</b>				29c. LICENSE NUMBER <b>D31761</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/25/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Brian M. O'Connor, MD 501 W. SEVENTH ST, FREDERICK, MD 21701</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12227

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fredericka Arnold</b>				2. Date of Death Month <b>April</b> Day <b>4</b> Year <b>1996</b>		3. Time of Death <b>6:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Magnolia Gardens Nursing Home</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>214 52 6037</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 11, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Mitchellville</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>18003 Mill Branch Place</b>				10f. Zip Code <b>20716</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Frederick Bottner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Teresa Fehnebert</b>			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	19a. Informant's Name/Relationship (Type, Print) <b>Rose Marie Fox Neice</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18003 Mill Branch Place Mitchellville Md. 20716</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>4/8/96 Suitland Maryland</b>		21. Signature of Funeral Service Licensee <b>Robert E. Evans Pres.</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715</b>				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis.</b> Due to (or as a consequence of): <b>b. Right hip fracture.</b> Due to (or as a consequence of): <b>c. Left heel pressure ulcer.</b> Due to (or as a consequence of): <b>d. Alzheimer's disease</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-5058.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Kevin G. Champaloux MD</b>		29c. License number <b>D42049</b>	
	29d. Date signed (Month, Day, Year) <b>April 5, 1996</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alain G. CHAMPALOUX MD. Upper Marlboro. Md. 20772</b>			
State Registrar	31. Date filed (Month, Day, Year) <b>APR 12 1996</b>				32. Registrar's Signature <b>J. H. [Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12228

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Henry Ballard</b>			2. Date of Death Month <b>April</b> Day <b>8</b> Year <b>1996</b>			3. Time of Death <b>1157</b>			
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>			
Funeral Director	5. Social Security Number <b>214-42-8138</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 15, 43</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Pocomoke City</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>7625 River Rd.</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean Conflict</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5 Yrs.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Rehabilitation Counselor</b>		16b. Kind of Business/Industry <b>Counselor &amp; Teacher</b>			
	17. Father's Name (First, Middle, Last) <b>Bit Miles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Ballard</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Shirley Ballard</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7625 River Rd. Pocomoke City, Md.</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Cemetery Unionville</b>		20c. Location - City or Town, State <b>Pocomoke City, Md.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Savage F.H.P.O. Bx. 46, 3812 New Church, Va. 23415</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE HEMORRHAGIC PANCREATITIS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>1 MONTH</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> <b>ACUTE RENAL FAILURE</b>									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number <b>044061</b>		29d. Date signed (Month, Day, Year) <b>4/8/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AKWASI APPAN 540 RIVERSIDE DRIVE SUITE 4 SALISBURY MD 21801</b>										
31. Date filed (Month, Day, Year) <b>APR 10 1996</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12229

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEN J. BITTNER				2. Date of Death Month: April 10, Day: 1996 Year: 1996		3. Time of Death 11:39 PM																											
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany																											
Funeral Director	5. Social Security Number 214-07-4147		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) SEPT 2 1915																											
	Usual Residence of Decedent		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND																											
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 524 LOUISIANA AVE.		10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.																											
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) B&O RAILROAD		16b. Kind of Business/Industry TRAINMAN/RAILROAD																													
	17. Father's Name (First, Middle, Last) IRA A. BITTNER				18. Mother's Name (First, Middle, Maiden Surname) ADDA CHRISTY																													
	19a. Informant's Name/Relationship (Type, Print) VIOLET M. BITTNER WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 LOUISIANA AVE. CUMBERLAND MARYLAND 21502																													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN CEMETERY		Date APRIL 13 1996		20c. Location - City or Town, State LAVALE, MARYLAND																											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502																													
	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Cerebrovascular Accident</td> <td>Due to (or as a consequence of):</td> <td>2 Years</td> </tr> <tr> <td>c.</td> <td>Hypoxemia</td> <td>Due to (or as a consequence of):</td> <td>1 Week</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Pneumonia	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	Cerebrovascular Accident	Due to (or as a consequence of):	2 Years	c.	Hypoxemia	Due to (or as a consequence of):	1 Week	d.		Due to (or as a consequence of):										
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d.			Due to (or as a consequence of):																															
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																				
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vik Poonai 955 Frederick Street Cumberland, Md. 21502																																		
<table border="1"> <tr> <td colspan="4">31. Date filed (Month, Day, Year) APR 12 1996</td> <td colspan="4">32. Registrar's Signature </td> </tr> </table>								31. Date filed (Month, Day, Year) APR 12 1996				32. Registrar's Signature 																						
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

No. 10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12230

## Certificate of Death

Reg. No.

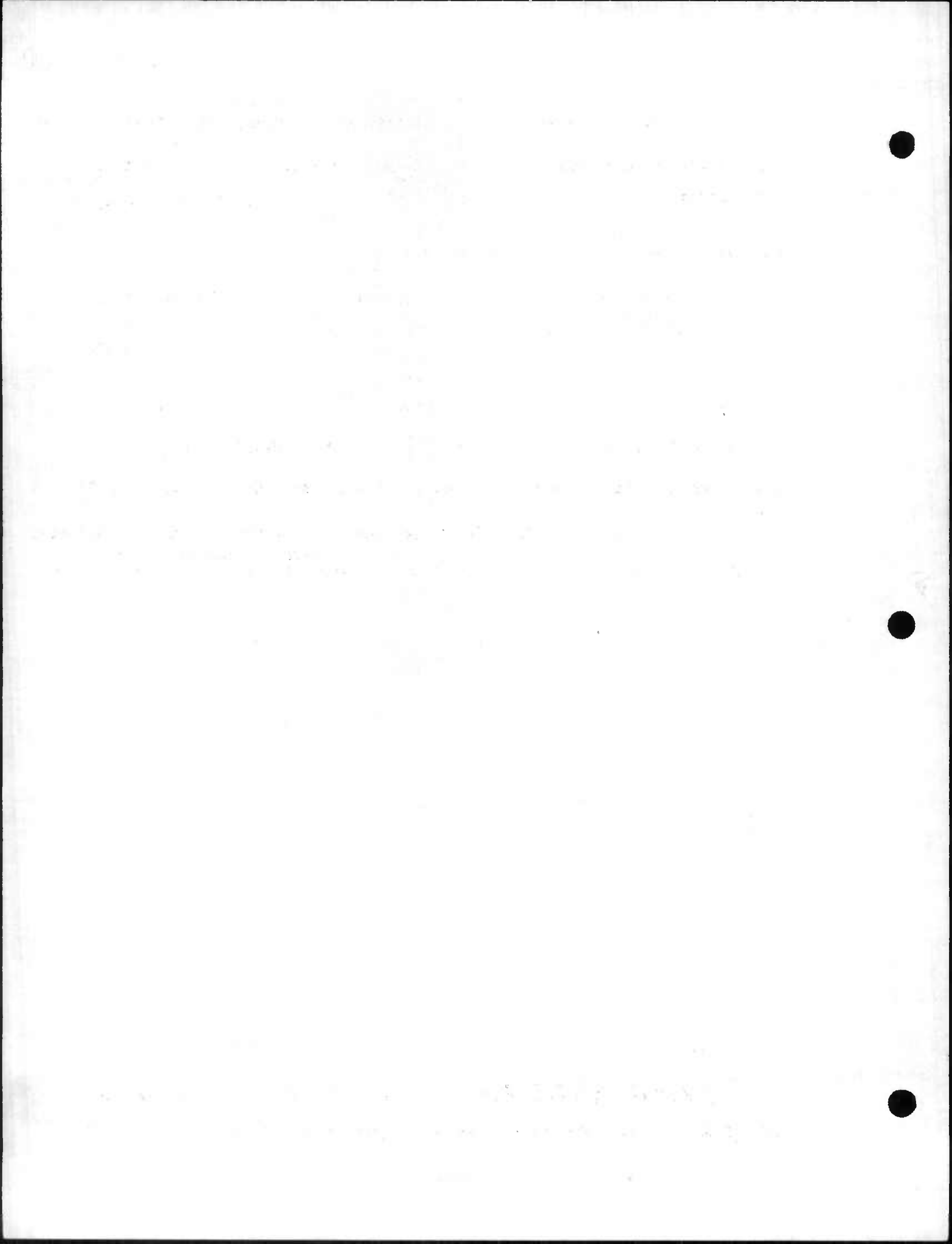
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruby LaRue Blentlinger			2. Date of Death Month Day Year March 26 1996		3. Time of Death 4:08 AM				
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick				
Funeral Director	5. Social Security Number 214-28-5419		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 24, 1931	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Frederick		10c. City, Town or Location New Market			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 6302 New London Road			10f. Zip Code 21774		10g. Citizen of What Country? United States				
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Winfield Scott Rippeon			18. Mother's Name (First, Middle, Maiden Surname) Pearl Virginia Curfman						
	19a. Informant's Name/Relationship (Type, Print) Ira Eldred Blentlinger, husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6302 New London Road New Market, MD 21774						
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 3/29/96		20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702						
To Be Completed by Physician/Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE MONTHS Due to (or as a consequence of): b. HYPERTENSION YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left Breast CA & post surgery mastectomy							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Robert R. Roberts MD			29c. License number D09867		29d. Date signed (Month, Day, Year) 03/27/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R R R ROBERTS MD 15013 McKaig Rd Frederick MD 21701-3319									
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 29 1996			32. Registrar's Signature 						
	State Registrar									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

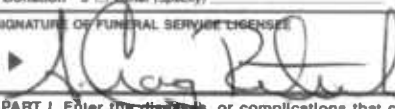
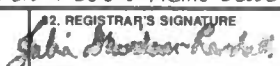
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 12231

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID Dare BROWN, III</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>1:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>236-14-9228</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 12 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WV</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>	
10c. CITY, TOWN OR LOCATION <b>Keyser</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>155 Willow Avenue</b>	
10f. ZIP CODE <b>26726</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+) <b>5 +</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cost Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Paper Manufacturing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>David Dare Brown, II</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marguerite Shumway</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Ruth Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>155 Willow Avenue Keyser, WV 26726</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Little Arlington Cemetery Apr 2, 1996</b>		20c. LOCATION — City or Town, State <b>Elkins, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Exacerbation of chronic Bronchitis + Emphysema with Respiratory failure</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mark Sagin</b>				29c. LICENSE NUMBER <b>D 35481</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/2/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Mark Sagin-4th Floor-Memorial Hospital-Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12232

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARY MARGARET BILLMYRE</b>						2. Date of Death Month Day Year <b>APRIL 17 1996</b>		3. Time of Death <b>7:25 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>						4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>			
<b>Funeral Director</b>	5. Social Security Number <b>234-38-8214</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT. 8, 1911</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
	Usual Residence of Decedent											
10a. State <b>WEST VA</b>		10b. County <b>MINERAL</b>		10c. City, Town or Location <b>RIDGELEY</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number <b>rr 36 POTOMAC STREET</b>				10f. Zip Code <b>26753</b>		10g. Citizen of What Country? <b>U.S.A.</b>						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHYSICAL THERAPIST</b>			16b. Kind of Business/Industry <b>HOSPITAL</b>					
17. Father's Name (First, Middle, Last) <b>CHARLES EDWARD CRAMPTON</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES SWAIN</b>						
19a. Informant's Name/Relationship (Type, Print) <b>RICHARD D. BILLMYRE</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4822 FAUNA LANE - INDIANAPOLIS, INDIANA 46234</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOUNTAIN VIEW CEMETERY</b>		Date <b>4/20/96</b>		20c. Location - City or Town, State <b>SHARPSBURG, MD</b>					
21. Signature of Funeral Service Licensee <i>Henry N. Upchurch</i>						22. Name and Address of Facility <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td style="width:60%; vertical-align: top;">           a. <b>Endstage Congestive Heart Failure</b>            Due to (or as a consequence of):            b. <b>Ischemic Myocardopathy</b>            Due to (or as a consequence of):            c. _____            Due to (or as a consequence of):            d. _____         </td> <td style="width:10%; vertical-align: top;">           Approximate Interval Between Onset and Death  <b>6 mos</b>   <b>3 yrs</b> </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Endstage Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Ischemic Myocardopathy</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <b>6 mos</b>  <b>3 yrs</b>
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Endstage Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Ischemic Myocardopathy</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <b>6 mos</b>  <b>3 yrs</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Gary Wagoner</i>		29c. License number <b>D22181</b>		29d. Date signed (Month, Day, Year) <b>APRIL 18, 1996</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary Wagoner, M.D. 925 Bishop Walsh Road Cumberland MD 21502</b>												
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>			32. Registrar's Signature <i>John Anderson-Randall</i>									

Baltimore, Maryland 21215-0020

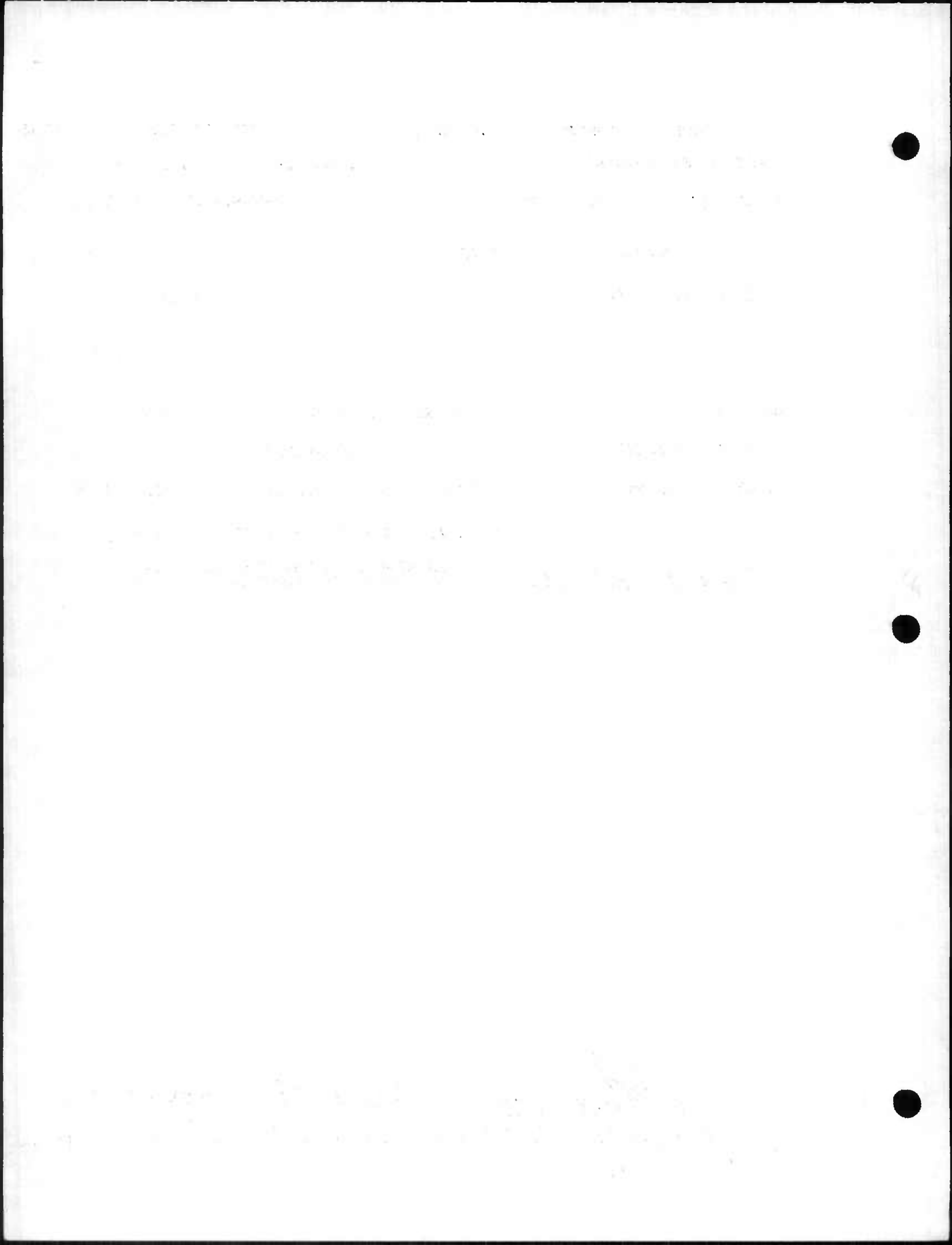
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12  
RDS



96 12233

Amended #s 9c, 19a, 20b, 4/15/96, 7/28, Allegany County  
 FOR  
 STATE  
 REGISTRAR  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL B BAILEY</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>15</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>2:30 A: M</b>	
4. SOCIAL SECURITY NUMBER <b>428-09-7630</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05/18/15</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Hattiesburg, M</b>				9. FACILITY NAME (If not institution, give street and number) <b>Devlin Manor Nursing Home</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland,</b>				11. COUNTY OF DEATH <b>Allegany</b>			
10a. STATE <b>WV</b>		10b. COUNTY <b>HARDY</b>		10c. CITY, TOWN OR LOCATION <b>MOOREFIELD</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>HC 70 BX 24 b</b>				10f. ZIP CODE <b>26836</b>		10g. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lumber Company</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Wood</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert S. Bailey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise NMN Brent</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Evelyn C. Bailey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC 70 BX 24 b Moorefield, WV 26836</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Olivet Cemetery 3/18</b>		20c. LOCATION — City or Town, State <b>Moorefield, WV</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>FRANK Funeral Home</b> <b>Box 89 - Moorefield, WV 26836</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>Aspiration</b> d. <b>Aspiration</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>AT Bollino MD</b>				29c. LICENSE NUMBER <b>D12565</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/15/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AT Bollino MD 955 Frederick St Cumberland MD 21112</b>							
31. DATE FILED (Month, Day, Year) <b>APR 15 1996</b>				32. REGISTRAR'S SIGNATURE <b>Jodie Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12234

## Certificate of Death

Reg. No.

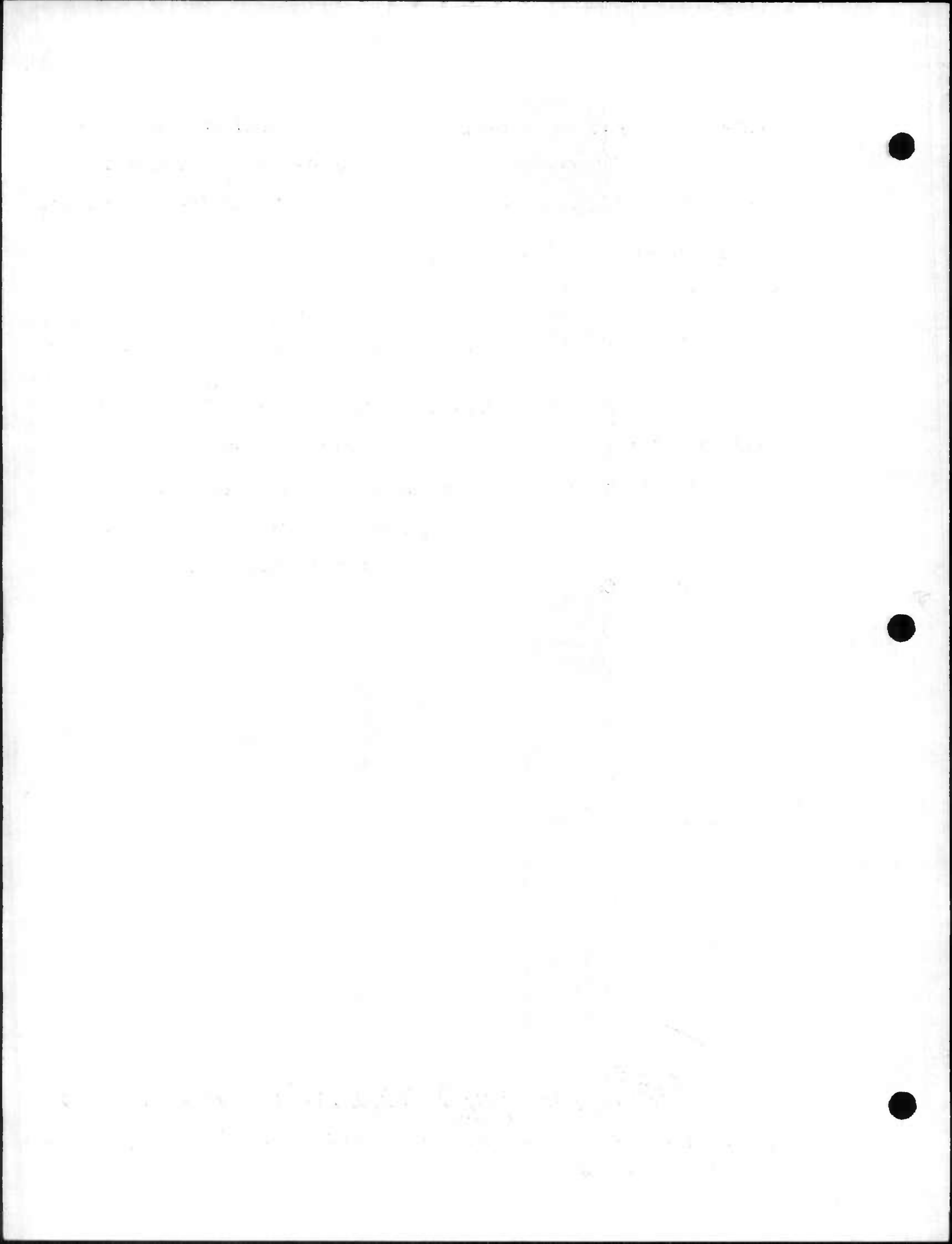
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER FRANK BOWLEY, JR.</b>				2. Date of Death Month Day Year <b>APRIL 14, 1996</b>		3. Time of Death <b>4:30 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>234-30-0499</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 25, 1923</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>West Va</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Ft. Ashby</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7 Jamie Street</b>				10f. Zip Code <b>26719</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Capt.-Co. Chdr. &amp; Reg. Coordinator</b>		16b. Kind of Business/Industry <b>W State Police &amp; W Dept. of Education</b>		
17. Father's Name (First, Middle, Last) <b>WALTER FRANK BOWLEY, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSA SHOEMAKER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ELOISE (PAINTER) BOWLEY</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 201 - FT. ASHBY, WV 26719</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		Date <b>4/17/96</b>		20c. Location - City or Town, State <b>PARSONS, WV</b>		
21. Signature of Funeral Service Licensee <i>Handy D. Yochum</i>				22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260 - FT. ASHBY, WV 26719</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Endstage Glioblastoma (Brain tumor)</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Gary Wagoner MD</i>		29c. License number <b>D22181</b>		29d. Date signed (Month, Day, Year) <b>APRIL 15, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary Wagoner M.D. 925 Bishop Walsh Road Cumberland MD 21502</b>								
31. Date filed (Month, Day, Year) <b>APR 15 1996</b>		32. Registrar's Signature <i>G. Davidson</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

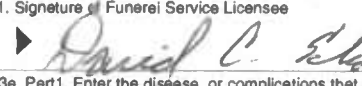


Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12235

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Margaret Justine Briguglio</b>				2. Date of Death Month <b>April</b> Day <b>14</b> Year <b>1996</b>				3. Time of Death <b>10:47 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Physicians Memorial Hospital</b>				4b. City, Town, or Location of Death <b>La Plata</b>				4c. County of Death <b>Charles</b>	
<b>Funeral Director</b>	5. Social Security Number <b>578-14-8766</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Dec. 15, 1921</b>		9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent										
10a. State <b>MD</b>			10b. County <b>Charles</b>			10c. City, Town or Location <b>Port Tobacco</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>7695 Locust Pl.</b>					10f. Zip Code <b>20677</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>		
17. Father's Name (First, Middle, Last) <b>Jess Quillin</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Mae Howard Quillin</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Ann Alonso</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7695 Locust Pl. Port Tobacco, MD 20677</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cem.</b>			Date <b>4/17/96</b>		20c. Location - City or Town, State <b>Clinton, MD</b>	
21. Signature of Funeral Service Licensee  <b>MO0945</b>					22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, INC.</b> <b>P.O. Box 567 LaPlata, MD 20646</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Myotonic Muscular Dystrophy</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>Recurrent Aspiration</u></p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>50 years</b></p> <p><b>2 years</b></p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> </div> <div style="width: 40%;"> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> </div> <div style="width: 70%;"> <p>26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</p> </div> <div style="width: 40%;"> <p>28a. Date of Injury (Month, Day, Year)</p> <p>28b. Time of Injury <b>M</b></p> <p>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> </div> <div style="width: 30%;"> <p>28d. Describe how injury occurred</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> </div> <div style="width: 40%;"> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> </div> </div>										
<p>29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p>										
29b. Signature and title of certifier 					29c. License number <b>D30484</b>			29d. Date signed (Month, Day, Year) <b>4/15/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles A. Umsella 4333 Old Branch Avenue Marlow Heights, MD 20748</b>										
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>					32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 12236

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Blanche Rebecca Bloom</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>12</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>9:00 P. M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-14-2542</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>72</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 9, 1923</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>11837 Robinwood Drive</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>11837 Robinwood Drive</i>			
10f. ZIP CODE <i>21742</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Decorator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home Interior</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Elbra O. Brown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Eula H. Harbaugh</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Wilbur N. Bloom</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11837 Robinwood Drive Hagerstown, MD 21742</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Smithsburg Cemetery April 16, '96</i>		20c. LOCATION — City or Town, State <i>Smithsburg, MD</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis L. Davis</i>	
22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, MD 21783</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Atherosclerotic Vascular Disease</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Type II, Carcinoma of Breast</i>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne E. Wray MD</i>				29c. LICENSE NUMBER <i>D 23815</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/16/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>19414 D Leitersburg Pike Hagerstown, MD 21742</i>							
31. DATE FILED (Month, Day, Year) <i>APR 18 1996</i>				32. REGISTRAR'S SIGNATURE <i>Jebbie Maclean-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12237

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Joseph Bleyer</b>						2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>2309</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Dorchester General Hospital</b>						4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>		
Funeral Director	5. Social Security Number <b>220-52-8526</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 19, 1949</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5306 Suburban Drive</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>U.S. Military</b>			16b. Kind of Business/Industry <b>Government</b>			
	17. Father's Name (First, Middle, Last) <b>John Joseph Bleyer, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Oneita Willey</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Yvonne C. Bleyer, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5306 Suburban Dr., Cambridge, MD. 21613</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Mem. Pk.</b>		Date <b>4-15</b>		20c. Location - City or Town, State <b>Cambridge, MD.</b>				
	21. Signature of Funeral Service Licensee <i>Curran-Bromwell</i>				22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiac Arrest</b> Due to (or as a consequence of): b. <b>Atherosclerotic heart disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										minutes  2 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Chayton Z. Raab</i>				29c. License number <b>D19289</b>				29d. Date signed (Month, Day, Year) <b>4/12/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Chayton Z. Raab MD PO Box 2636 Salisbury MD 21801</b>											
31. Date filed (Month, Day, Year) <b>APR 15 1996</b>				32. Registrar's Signature <i>Julia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12238

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Grace G. Black</b>				2. Date of Death Month <b>April</b> Day <b>13</b> Year <b>1996</b>		3. Time of Death <b>0219</b>	
	4e. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>212-14-8261</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 6, 1918</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>314 Curtis Avenue</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>			16b. Kind of Business/Industry <b>Restaurant</b>	
17. Father's Name (First, Middle, Last) <b>Samuel E. Gilbert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Abigail Stine</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Julius A. Jodlbauer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 East Main Street - Elkton, MD 21921</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gilpin Manor Memorial Park</b>		Date <b>4-17-1996</b>		20c. Location - City or Town, State <b>Elkton, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Doreen S. Hicks</b>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Ischemic Cardiomyopathy</b> Due to (or as a consequence of): <b>c. ASCVD</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>Days</b> <b>Months</b> <b>Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>PSVT / Atrial Fibrillation</b> <b>Sepsis / Pneumonia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Doreen S. Hicks</b>		29c. License number <b>A30291</b>		29d. Date signed (Month, Day, Year) <b>4/15/96</b>		
29. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Dehitzio M.D. 111 W. High St Ste 204 Elkton, Md 21921</b>								
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>		32. Registrar's Signature <b>Juli A. ...</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12239

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry Gilbert Baker</b>				2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>0837</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>145-14-3902</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Rising Sun</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>47 Cherry Street</b>		10f. Zip Code <b>21911</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>				
17. Father's Name (First, Middle, Last) <b>Charles E. Baker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Stout</b>				
19a. Informant's Name/Relationship (Type, Print) <b>John P. Baker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 South 9th Street - Millville, NJ 08332</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Company</b>		20c. Location - City or Town, State <b>West Chester, PA</b>		20d. Date <b>4-12-1996</b>		
21. Signature of Funeral Service Licensee <b>Donna S. Hicks</b>				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Brain death</b> Due to (or as a consequence of): b. <b>Hypoxic Encephalopathy</b> Due to (or as a consequence of): c. <b>Cardiac Arrest</b> Due to (or as a consequence of): d. <b>Subarachnoid Bleeding</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Frederick Bernstein M.D.</b>		29c. License number <b>D47561</b>		29d. Date signed (Month, Day, Year) <b>4/11/96</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick Bernstein M.D. 111 W. High St. Ste 204 ELKTON, Md 21921</b>								
31. Date filed (Month, Day, Year) <b>APR 18 1996</b>		32. Registrar's Signature <b>John H. Russell</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

*[Faint handwritten notes]*

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12240

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) Howard William Brown				2. Date of Death Month: April Day: 7 Year: 1996		3. Time of Death 6:40AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
<b>Funeral Director</b>	5. Social Security Number 220-03-6121		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 28, 1920	
	9. Birthplace (State or Foreign Country) Washington D. C.							
<b>To Be Completed by Funeral Director</b>	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7082 Catalpa Road				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Years: 5-18-42 to 10-31-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Marketing Manager		16b. Kind of Business/Industry Telephone Company	
	17. Father's Name (First, Middle, Last) Charles M. Brown				18. Mother's Name (First, Middle, Maiden Surname) Beulah Hopkins			
	19a. Informant's Name/Relationship (Type, Print) Mildred Johnstone Brown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7082 Catalpa Rd., Frederick, Md. 21703			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date April 8, 1996		20c. Location - City or Town, State Smithsburg, Maryland	
	21. Signature of Funeral Service Licensee <i>Richard C. Basford</i> M00021				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory Arrest</i> Due to (or as a consequence of): b. <i>metastatic squamous cell</i> Due to (or as a consequence of): c. <i>carcinoma of skin</i> Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 12 MO							
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Nodular lymphoma</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D1462C		29d. Date signed (Month, Day, Year) 4/7/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>PG Records 501 W. Scott St. Frederick MD</i>								
31. Date filed (Month, Day, Year) APR 08 1996				32. Registrar's Signature <i>[Signature]</i>				

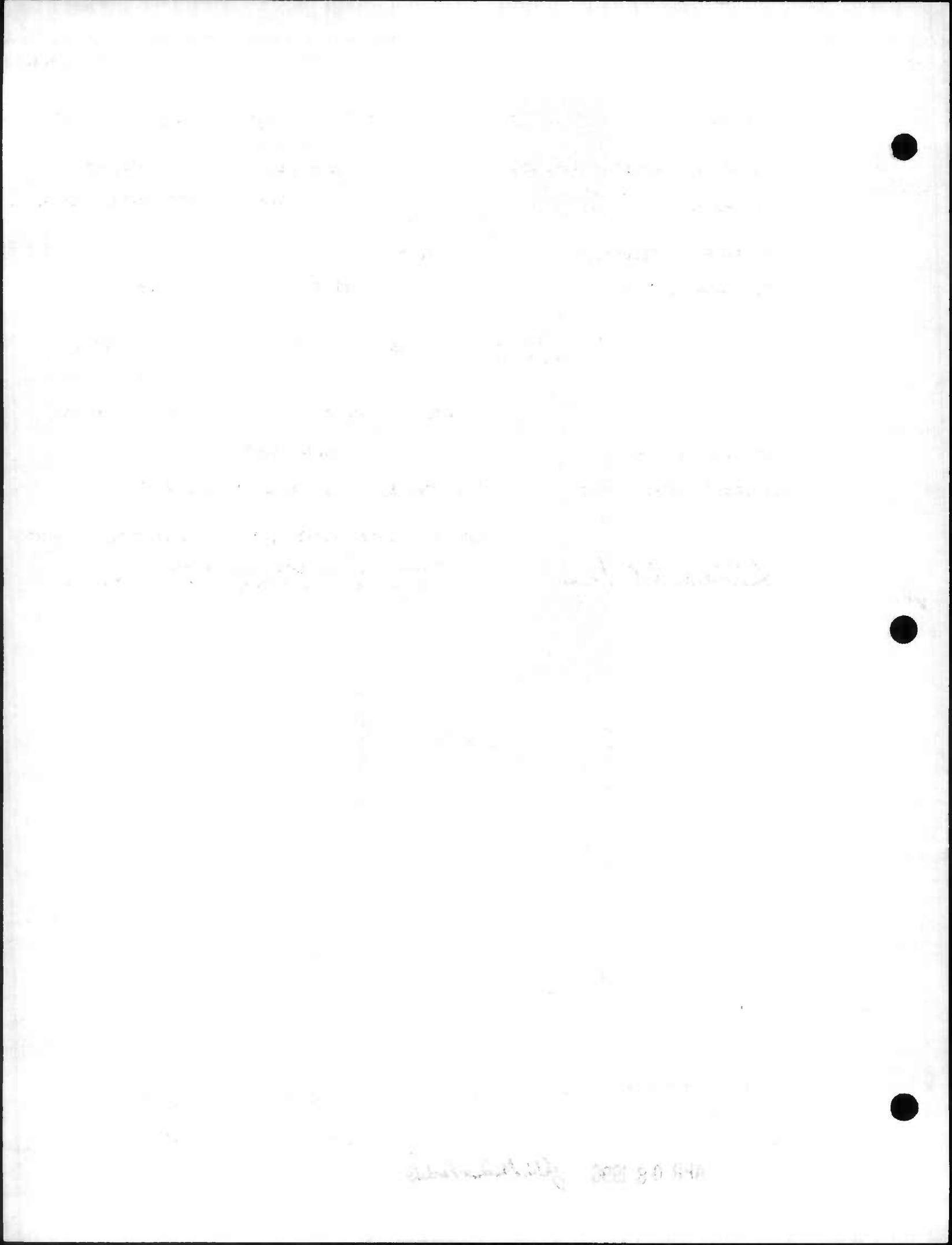
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

**State  
Registrar**



DHMH-16 Rev. 1/89

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96 12242

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN G BOYER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>96</b>		3. TIME OF DEATH <b>7:58 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-28-2347</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 24 04</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>W. Hyattsville</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2033 Powhatan Road</b>	
10f. ZIP CODE <b>20782</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Note Teller</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William R. Gue</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>George Edna Burns</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Alton Boyer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3409 Lowell St., N.W. Washington, D.C. 20016</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Damascus Methodist 4/1/96</b>		20c. LOCATION — City or Town, State <b>Damascus, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Olin L. Molesworth</b>				22. NAME AND ADDRESS OF FACILITY <b>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Insufficiency</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Chronic Interstitial Lung Disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>3/28/96</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Attending</b>				29c. LICENSE NUMBER <b>D 24886</b>			
29d. DATE SIGNED (Month, Day, Year) <b>3/28/96</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print) <b>Max E. G. 9801 Georgia Ave. Silver Spring Md.</b>			
31. DATE FILED (Month, Day, Year) <b>APR 01 1996</b>				32. REGISTRAR'S SIGNATURE <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12243

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy Clinton Baugher, Jr.				2. Date of Death Month Day Year March 24, 1996		3. Time of Death 6:50 pm	
	4e. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-28-3928		6. Sex XXM 2□ F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 11, 1926	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Adamstown		10d. Inside City Limits 1□ Yes 2X No		
10e. Street and Number 5303 Doubs Road				10f. Zip Code 21710		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1□ Never Married 2X Married 3□ Widowed 4□ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2□ No If Yes, Give Year or Dates: 1955-1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2X No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pool Technician		18b. Kind of Business/Industry Pool Construction		
17. Father's Name (First, Middle, Last) Roy Clinton BAUGHER, SR.				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth WILHIDE				
19e. Informant's Name/Relationship (Type, Print) Mrs. Frances D. Baugher, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5303 Doubs Road, Adamstown, Maryland 21710				
20a. Method of Disposition 1X Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Manor Cemetery, March 27, 1996		Date March 27, 1996		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee Richard E. Long M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701				
23e. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral thrombosis &amp; embolus</i> Due to (or as a consequence of): b. <i>Coronary artery disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4d Twenty
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4X Unknown		
						24e. Was an autopsy performed? 1□ Yes 2X No		
						24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No		
25. Was case referred to medical examiner? 1□ Yes 2X No		28. Place of Death (Check only one) Hospital: 1X Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 8□ Other (Specify)						
27. Manner of Death 1X Natural 5□ Pending Investigation 2□ Accident 6□ Could not be determined 3□ Suicide 4□ Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1□ Yes 2□ No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Robert S. Hughes, MD				29c. License number D05411		29d. Date signed (Month, Day, Year) 3/25/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Robert S. Hughes, MD 700 Montclair Avenue, Frederick, Maryland 21701								
31. Date filed (Month, Day, Year) MAR 26 1996		32. Registrar's Signature John Davidson Randall						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Madaline BOWIE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 23, 1996</b>		3. TIME OF DEATH <b>10:30am M</b>	
4. SOCIAL SECURITY NUMBER <b>220-10-5837</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 12, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Citizens Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Frederick</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1900 Rosemont Avenue</b>	
10f. ZIP CODE <b>21702</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Edwin GOODMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Virginia UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Commission on Aging</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>520 N Market Street, Frederick, Maryland 21701</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fairview Cemetery Mar 27, 1996 Frederick, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles E. Hicks III</i>				22. NAME AND ADDRESS OF FACILITY <b>Hicks Funeral Service 21401 1922 Forest Drive, Annapolis Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>atherosclerotic heart disease</i></b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b><i>Osteoarthritis</i></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Casper E. Cline, III</i>				29c. LICENSE NUMBER <b>D16428</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 26, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 27 1996</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12245

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTABELLE Butler

2. Date of Death

Month Day Year  
APR 13 1996

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Community Hospital Cheverly

4b. City, Town, or Location of Death

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

575-22-0303

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9/26/21

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

P.G.

10c. City, Town or Location

Fairmont Height

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1006 59th Ave.

10f. Zip Code

20127

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US Government

16b. Kind of Business/Industry

HUD

17. Father's Name (First, Middle, Last)

John Henry Wise

18. Mother's Name (First, Middle, Maiden Summa)

Mary Walker

19a. Informant's Name/Relationship (Type, Print)

DeWitt Butler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1006 59th Ave. Fairmont Heights, Md. 20127

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Vetern Cemetery 4/10/96 Cheltenham, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Dunn &amp; Sons 1432 U St. NW DC 20009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

CVA/Cardio Vascular Arrest 2 day.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.

Diabetes mellitus.

Ca Breast. Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Penny Lewis M.D.

29c. License number

042580

29d. Date signed (Month, Day, Year)

4/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.S. AJLA M.D. 5632 ANNAPOLIS RD Suite #14.  
BLADENBURG MD 20710

31. Date filed (Month, Day, Year)

APR 12 1996

32. Registrar's Signature

John H. H. H. H.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12-2-77

1. The first part of the report is a summary of the work done during the last year.

2. The second part is a detailed description of the experiments carried out.

3. The third part is a discussion of the results obtained and their significance.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of the names of the people who have helped me during the last year.

6. The sixth part is a list of the names of the people who have helped me during the last year.

7. The seventh part is a list of the names of the people who have helped me during the last year.

8. The eighth part is a list of the names of the people who have helped me during the last year.

9. The ninth part is a list of the names of the people who have helped me during the last year.

10. The tenth part is a list of the names of the people who have helped me during the last year.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MARY DELORIS BAKER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 4, 1996</b>		3. TIME OF DEATH <b>2:30 P</b>	
4. SOCIAL SECURITY NUMBER <b>213-54-8637</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 13, 1951</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE'S</b>		10c. CITY, TOWN OR LOCATION <b>TEMPLE HILLS</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3604 ORME DRIVE</b>				10f. ZIP CODE <b>20748</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2YRS.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERICAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE HENRY HAWKINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>THERESA V. THOMPSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES BAKER/ HUSBAND</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3604 ORME DR. TEMPLE HILLS, MARYLAND 20748</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEM. 4/8/96</b>		20c. LOCATION — City or Town, State <b>CHELTENHAM, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward L. Braxton</i>				22. NAME AND ADDRESS OF FACILITY <b>MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF THE BREAST WITH METASTASIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>CANCER OF THE BREAST WITH METASTASIS</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CANCER OF THE COLON</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-18545</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 8, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>6188 Oxon Hill Rd. #601 Oxon Hill, Md. 20745</b>							
31. DATE FILED (Month, Day, Year) <b>4 APR 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1927 2 11 112

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12247

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>GERARDO BONIFACIO</b>					2. Date of Death Month <b>APRIL</b> Day <b>6</b> Year <b>1996</b>		3. Time of Death <b>4:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HYATTSVILLE MANOR</b>					4b. City, Town, or Location of Death <b>HYATTSVILLE</b>		4c. County of Death <b>PRINCE GEORGE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>UNAVAILABLE</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>27</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>APRIL 23 1968</b>		9. Birthplace (State or Foreign Country) <b>EL SALVADOR</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5518 DOWGATE COURT #208</b>					10f. Zip Code <b>20851</b>		10g. Citizen of What Country? <b>EL SALVADOR</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>HISPANIC</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECURITY GUARD</b>			16b. Kind of Business/Industry <b>RAMANDA INN</b>	
17. Father's Name (First, Middle, Last) <b>OVIDIO CASTRO</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARIA BONIFACIO</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARIA I. BONIFACIO</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5518 DOWGATE COURT #208 ROCKVILLE, MD 20851</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FAMILY CEMETERY</b>		Data <b>APR. 13 96</b>		20c. Location - City or Town, State <b>SAN MIGUEL, EL SALVADOR</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASHINGTON, D.C. 20010</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p><b>Immediata Causa (Final disease or condition resulting in death)</b></p> <p style="font-size: 1.5em; margin-left: 40px;"><b>AIDS</b></p> <p style="font-size: 1.5em; margin-left: 40px;"><b>TOXOPLASMOSIS</b></p> <p style="font-size: 1.5em; margin-left: 40px;"><b>CARDIOPULMONARY FAILURE</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier <b>Dr. Robert D. Skipworth</b>				
29c. License number <b>028906</b>					29d. Date signed (Month, Day, Year) <b>April 9, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>585 Main Street Laurel Maryland 20707</b>									
31. Date filed (Month, Day, Year) <b>APR 10 1996</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12248**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID BELL</b>				2. Date of Death Month Day Year <b>APRIL 05 1996</b>		3. Time of Death <b>12:45 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Fort Washington Hospital</b>				4b. City, Town, or Location of Death <b>Fort Washington</b>		4c. County of Death <b>Prince Georges</b>		
Funeral Director	5. Social Security Number <b>431-42-2358</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01-10-22</b>		9. Birthplace (State or Foreign Country) <b>Wynn, Arkansas</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Clinton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>10407 Slocum Ct.</b>			10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steamfitter</b>			16b. Kind of Business/Industry <b>Private</b>			
	17. Father's Name (First, Middle, Last) <b>William Bell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Willie Bell</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>DeMarco Bell Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10407 Slocum Ct., Clinton, MD 20735</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Cemetery</b>		Date <b>04-13-96</b>		20c. Location - City or Town, State <b>Worth, Ill.</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Bianchi Funeral Service 3718 22nd St. NE, Washington, DC 20018-3004</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adenocarcinoma of Lung</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Victor E. Henry MD</b>		29c. License number <b>D20986</b>		29d. Date signed (Month, Day, Year) <b>4-8-96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11701 LIVINGSTON RD FT WASHINGTON MD 20744</b>									
31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

100-100000-100000

100-100000-100000



40



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12249

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James Lawrence Braddock</i>		2. Date of Death Month <i>April</i> , Day <i>6</i> , Year <i>1996</i>		3. Time of Death <i>9 AM</i>
	4a. Facility Name (If not Institution, give street and number) <i>7201 Lanham Lane</i>		4b. City, Town, or Location of Death <i>FT. WASH.</i>		4c. County of Death <i>Prince Georges</i>
Funeral Director	5. Social Security Number <i>228-21-3099</i>	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>66</i> Yrs.	If Under 1 Year Months <i>0</i> Days <i>0</i>	If Under 24 Hrs. Hours <i>0</i> Min. <i>0</i>
	Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) <i>April 18 1929</i>		9. Birthplace (State or Foreign Country) <i>Bealeys, W. VA.</i>
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>Prince Georges</i>	10c. City, Town or Location <i>FT. WASHINGTON</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>7201 Lanham Lane</i>		10f. Zip Code <i>20744</i>		10g. Citizen of What Country? <i>UNITED STATES</i>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1950-52</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2 yrs.</i> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>BUS DRIVER</i>		16b. Kind of Business/Industry <i>PRIVATE</i>
	17. Father's Name (First, Middle, Last) <i>John Braddock</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Eleanor Brooks</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Grace Braddock</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7201 Lanham Lane FT. WASH. MD, 20744</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Cheltenham</i>		20c. Location - City or Town, State <i>Cheltenham, MD</i>
	21. Signature of Funeral Service Licensee <i>Leroy Hodges</i>		22. Name and Address of Facility <i>Holmes-Edwards Villa 3910 Silver Hill Rd Suitland, MD, 20746</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cancer, prostate &amp; bone</i> Due to (or as a consequence of):				
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</i> Due to (or as a consequence of):				
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <i>1</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>Augusto P. Rodriguez MD</i>		29c. License number <i>D21230</i>		29d. Date signed (Month, Day, Year) <i>April 6, 1996</i>
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cap Spr. Md 20748</i>				
State Registrar	31. Date filed (Month, Day, Year) <i>APR 11 1996</i>		Registrar's Signature <i>John Anderson</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

①





96 12250

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CONSTANCE E. COLE</b>				2. DATE OF DEATH MONTH <b>4</b> / DAY <b>7</b> / YEAR <b>1996</b>		3. TIME OF DEATH <b>6:55 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>579-26-6733</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>92</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12/11/03</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kansas</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>107 W. Federal Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Snow Hill</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>107 W. Federal Street</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receptionist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Secretarial</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Thomas Hulehan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nona Monihan Hulehan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Shirley Monti</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 W. Federal Street, Snow Hill, Md. 21863</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>whatcoat Meth. Cemetery</b>		20c. LOCATION — City or Town, State <b>4/12 Snow Hill, Md. 21863</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Dennis</i>				22. NAME AND ADDRESS OF FACILITY <b>Dennis Funeral Home P.O. Box 87, Snow Hill, Md. 21863</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Parkinson's Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>25 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patricia M. Moore MD</i>				29c. LICENSE NUMBER <b>046490</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/7/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Patricia Moore MD 309 Timmons St.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12251

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Tilghman Cheesman, Sr.

2. Date of Death

April 14, 1996 Year

3. Time of Death

1:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mallard Bay Nursing Home

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-28-1992

6. Sex

M 20 F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 2, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

East New Market

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

5730 Linkwood Road

10f. Zip Code

21631

10g. Citizen of What Country?

US

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bridge Tender

16b. Kind of Business/Industry

State Employee

17. Father's Name (First, Middle, Last)

James Monroe Cheesman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Sellers

19a. Informant's Name/Relationship (Type, Print)

Kay E. Waldsachs-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

800 Church Street Cambridge, Maryland 21613

20a. Method of Disposition

20 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

East New Market Cemetery

Date

4/17

20c. Location - City or Town, State

East New Market, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.  
700 Locust Street Cambridge, Maryland 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the lung

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident investigation  
30 Suicide 60 Could not be  
40 Homicide determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-28205

29d. Date signed (Month, Day, Year)

April 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edmund J. MacLaughlin 4 Aurora St., Cambridge, Md 21613

31. Date filed (Month, Day, Year)

APR 16 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
9050.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, PER MED  
FILM G-735 5/1/96 t,t

State of Maryland / Department of Health and Mental Hygiene

96 12252

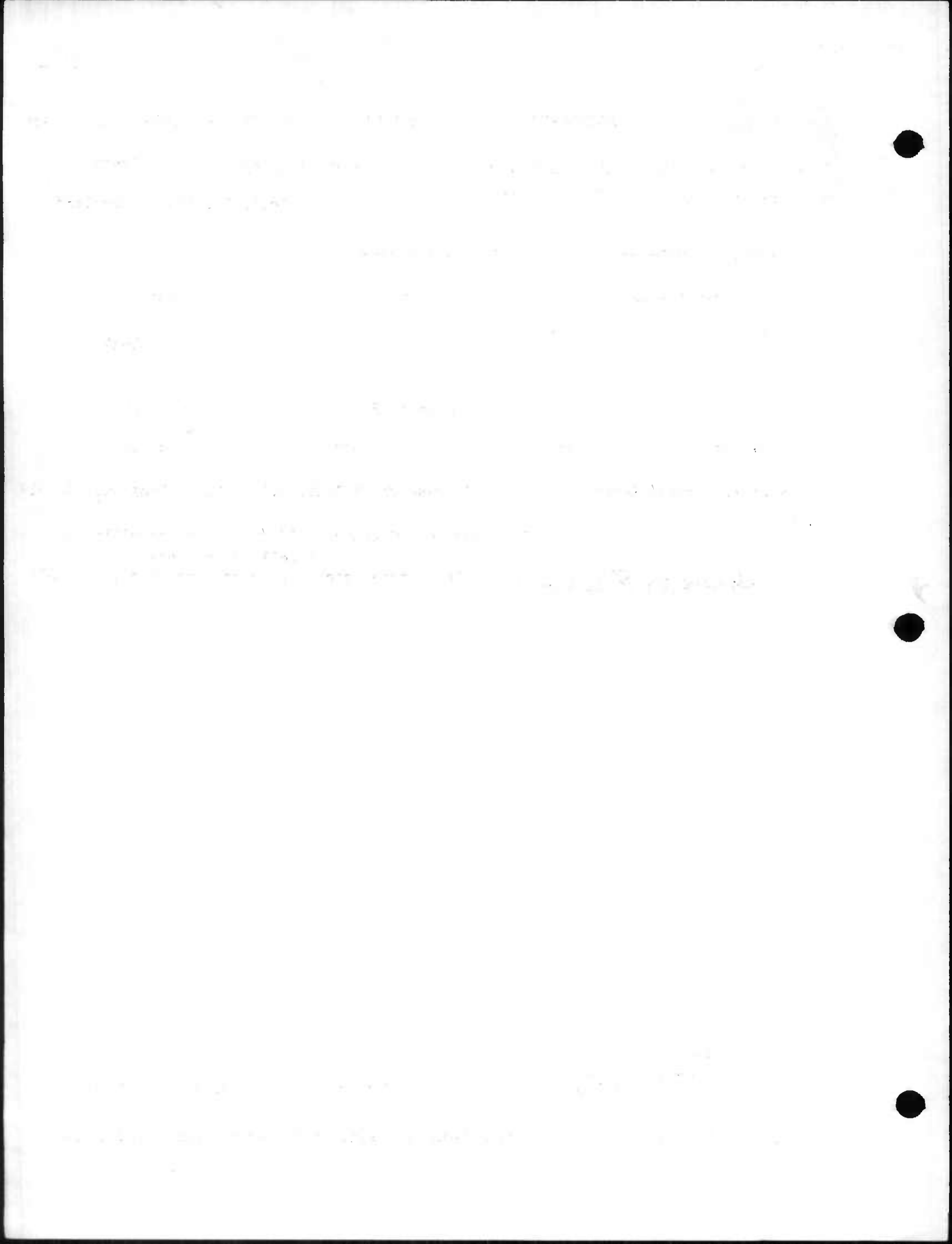
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AUDREY MARGARET CHASE</b>		2. Date of Death <b>MARCH 31, 1996</b>		3. Time of Death <b>11:11 AM.</b>
	4e. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>Calvert</b>
Funeral Director	5. Social Security Number <b>217-72-9065</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>41 Yrs.</b>	If Under 1 Year Months Days <b>0 0</b>	If Under 24 Hrs. Hours Min. <b>0 0</b>
	8. Date of Birth (Month, Day, Year) <b>Sept. 12, 1954</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Chesapeake Beach</b>	
10d. Inside City Limits <b>1 Yes 2 No</b>					
10e. Street and Number <b>6523 10th Street</b>		10f. Zip Code <b>20732</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>	
14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own home</b>	
17. Father's Name (First, Middle, Last) <b>Julius Chase</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Mackall</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary R. Thomas/sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5929 East Capitol St. S.E. #506 Washington, D.C. 20019</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Mem. Gardens</b>		20c. Location - City or Town, State <b>4/5/96 Davidsonville, MD</b>	
21. Signature of Funeral Service Licensee <i>Spencer E. Sewell</i>		22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>immediate Cause (Final disease or condition resulting in death)</p> <p>e. <b>CARDIAC ARRHYTHMIA DUE TO MYOCARDIAL INTERSTITIAL FIBROSIS</b></p> <p>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>					
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>					
24a. Was an autopsy performed? <b>1 Yes 2 No</b>					
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>					
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>0 0</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>					
29b. Signature and Title of certifier <i>David R. Fowler</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 1, 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>		32. Registrar's Signature <i>Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 12253

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kevin J. Clarke</b>				2. DATE OF DEATH <b>APRIL 6, 1996</b> MONTH <b>04</b> DAY <b>06</b> YEAR <b>96</b>		3. TIME OF DEATH <b>2:30 p M</b>	
4. SOCIAL SECURITY NUMBER <b>200-12-8440</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH <b>OCTOBER 10/31/25</b> (Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Charlotte Hall MD</b>		9c. COUNTY OF DEATH <b>St. Mary's</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>MD</b>		10c. CITY, TOWN OR LOCATION <b>Charlotte Hall</b>	
10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>				10e. STREET AND NUMBER <b>Rt. 2 Box 5, Charlotte Hall MD</b>			
10f. ZIP CODE <b>20622</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE YEAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 2</b> <b>College (1-4 or 5+) :</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Social Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PA. State Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Terrence Clarke</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Clarke</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kevin J. Clarke, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Killarney Hershey, PA 17033</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Indiantown Gap Nat. Cem. 4/11/96</b>		20c. LOCATION — City or Town, State <b>Indiantown, PA</b>		20d. DATE <b>4/11/96</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David C. Echols</b> <b>MO0945</b>				22. NAME AND ADDRESS OF FACILITY <b>AREHART-ECHOLS FUNERAL HOME, INC.</b> <b>P.O. Box 567 LaPlata, MD 20646</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Metastatic Colon Ca</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b>Brain Metastasis</b> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D 37588</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/6/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1545 Stoneligh 135 W. Daves Beck Prince Georges Md 20678</b>							
31. DATE FILED (Month, Day, Year) <b>APR 16 1996</b>				32. REGISTRAR'S SIGNATURE <b>Johi Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12254

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HATTIE MAY COLLINS</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>16</b> , YEAR <b>1996</b> AR		3. TIME OF DEATH <b>11:15 a</b> M	
4. SOCIAL SECURITY NUMBER <b>217-10-7569</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 2, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WV</b>		9a. FACILITY NAME (If not institution, give street and number) <b>CUMBERLAND NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MD</b>			
10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>15 Browning Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Kelly-Springfield Tire Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elvis Jenkins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie (Disapenet)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gerald Collins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Browning Street; Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		DATE <b>04/19</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 week</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Bilateral Cerebrovascular Accidents</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D33280</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 17, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Sunil Gupta; 625 Kent Avenue; Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 17 1996</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12255

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALICE ELIZABETH CAMPBELL</b>				2. Date of Death Month Day Year <b>APRIL 15, 1996</b>				3. Time of Death <b>0009 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>				4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>172-03-0673</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Under 1 Year Months Days		9. Under 24 Hrs. Hours Min.	
	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>55 Frost Village</b>	
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Secretary</b>		16b. Kind of Business/Industry <b>Office</b>		17. Father's Name (First, Middle, Last) <b>nfn</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>nmn</b>		19a. Informant's Name/Relationship (Type, Print) <b>Robert Wellings--friend</b>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Restlawn Memorial Gardens 04/18</b>		20c. Location - City or Town, State <b>LaVale, MD</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Scarpelli Funeral Home Cumberland, MD 21502</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Ventricular Fibrillation</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Approximate Interval Between Onset and Death <b>1 hr.</b>  <b>Unknown</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D09157</b>		29d. Date signed (Month, Day, Year) <b>April 15, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502</b>	
	31. Date filed (Month, Day, Year) <b>APR 16 1996</b>		32. Registrar's Signature 		33. Registrar's Name <b>John Davidson-Randall</b>		34. Registrar's Title <b>Registrar</b>		35. Registrar's Address <b>State Registrar</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



ITEM: 28c, PER DR. FILM G-735  
5/15/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 12256

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES A. CASTEEL				2. Date of Death Month Day Year April 9, 1996		3. Time of Death 10:40 P		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 219-03-8952		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 3, 1920	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number Route 8 Box 433				10f. Zip Code 21502		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) retired		16b. Kind of Business/Industry textile			
17. Father's Name (First, Middle, Last) Mitchell E. Casteel				18. Mother's Name (First, Middle, Maiden Surname) Martha E. (nmn)					
19a. Informant's Name/Relationship (Type, Print) Thelma P. Casteel				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 8 Box 433; Cumberland, MD 21502					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 04/12		Date 04/12		20c. Location - City or Town, State LaVale, MD			
21. Signature of Funeral Service Licensee James F. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Lung Cancer Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. EMPYEMA Due to (or as a consequence of): d. Emphysema Due to (or as a consequence of):  Approximate interval Between Onset and Death Five Months One Month One Month									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. V. Poonai		29c. License number D 36766		29d. Date signed (Month, Day, Year) April 11, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. V. Poonai 955 Frederick St. Cumberland, MD 21502									
31. Date filed (Month, Day, Year) APR 12 1996				32. Registrar's Signature John Harrison Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



96 12257

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMILY E. CHAPMAN				2. DATE OF DEATH MONTH DAY YEAR APRIL 6 1996		3. TIME OF DEATH 15:33 M	
4. SOCIAL SECURITY NUMBER 215-18-8550		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 22 1908	
8. BIRTHPLACE (State or Foreign Country) WV				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE WV		10b. COUNTY Mineral	
10c. CITY, TOWN OR LOCATION Keyser				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 500 Carskadon Lane	
10f. ZIP CODE 26726				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cutter		16b. KIND OF BUSINESS/INDUSTRY Paper Manufacturing	
17. FATHER'S NAME (First, Middle, Last) Frederick C. Evans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne E. Dawson			
19a. INFORMANT'S NAME (Type/Print) Emily D. Paitsel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1570 Beacon Street Keyser, WV 26726			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Philos Cemetery April 10 1996		20c. LOCATION — City or Town, State Westernport, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Insufficiency DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: Five Days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Right Hemicolectomy DUE TO (OR AS A CONSEQUENCE OF): Five Days c. Adenocarcinoma of Cecum DUE TO (OR AS A CONSEQUENCE OF): One Year d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mitral Stenosis and Pulmonary Hypertension Organic Brain Syndrome DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 14393		29d. DATE SIGNED (Month, Day, Year) April 11 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/print) Frederick Miltenberger M.D. Johnson Heights Medical Bldg. Cumberland MD 21502							
31. DATE FILED (Month, Day, Year) APR 12 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12258

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM RALPH CLARK				2. DATE OF DEATH MONTH DAY YEAR APRIL 9 96		3. TIME OF DEATH 2245P. M	
4. SOCIAL SECURITY NUMBER 216-09-2984		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 23, 1918	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH ALLEGANY			
10a. FACILITY NAME (If not institution, give street and number) 11201 PAULINE AVENUE				10b. CITY, TOWN OR LOCATION OF DEATH CORRIGANVILLE		10c. COUNTY OF DEATH ALLEGANY	
10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
10e. STATE MD				10f. COUNTY ALLEGANY		10g. CITY, TOWN OR LOCATION CORRIGANVILLE	
10h. STREET AND NUMBER P. O. BOX 12, 11201 PAULINE AVENUE				10i. ZIP CODE 21524		10j. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY TIRE MANUFACTURING	
17. FATHER'S NAME (First, Middle, Last) LEWIS T. CLARK				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERNETTA BEARD			
19a. INFORMANT'S NAME (Type/Print) BETTY JANE CLARK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 12, CORRIGANVILLE, MD 21524			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. CARMEL LUTHERAN CEM. 13, 1996		20c. LOCATION — City or Town, State RD 4, MEYERSDALE, PA 15552	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harvey H. Zeigler				22. NAME AND ADDRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUPLICATE (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUPLICATE (OR AS A CONSEQUENCE OF): c. DUPLICATE (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 2m11 24x15	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CIRRHOSIS OF LIVER						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Donald F. Manger		29c. LICENSE NUMBER 001231	
29d. DATE SIGNED (Month, Day, Year) APR 11 1996				29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD F. MANGER DME MD 11600 BEDFORD ROAD, CUMBERLAND, MD 21502		29f. DATE FILED (Month, Day, Year) APR 11 1996	
30. REGISTRAR'S SIGNATURE John H. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



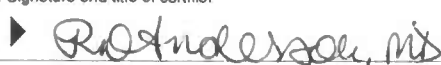
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12259

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY Lorraine CHAMBERS						2. Date of Death Month Day Year APRIL 16, 1996		3. Time of Death 5:00 AM													
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death Baltimore													
Funeral Director	5. Social Security Number 217-30-6145		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Sept 13 1936		9. Birthplace (State or Foreign Country) Pennsylvania													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 10944 Knotty Pine Drive				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.																
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Part Owner			16b. Kind of Business/Industry Building Supplies															
17. Father's Name (First, Middle, Last) Merle Shindle						18. Mother's Name (First, Middle, Maiden Surname) Mary Shaffer																
19a. Informant's Name/Relationship (Type, Print) Russell L. Chambers						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10944 Knotty Pine Drive Hagerstown, Md. 21740																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-19-96		Date		20c. Location - City or Town, State Hagerstown, Maryland															
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>HYPERKALEMIA</td> <td>12 HOURS</td> </tr> <tr> <td>b.</td> <td>Renal Failure</td> <td>10 DAYS</td> </tr> <tr> <td>c.</td> <td>SEPSIS</td> <td>3 WEEKS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	HYPERKALEMIA	12 HOURS	b.	Renal Failure	10 DAYS	c.	SEPSIS	3 WEEKS	d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	HYPERKALEMIA	12 HOURS																			
	b.	Renal Failure	10 DAYS																			
	c.	SEPSIS	3 WEEKS																			
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier 						29c. License number M6222		29d. Date signed (Month, Day, Year) APRIL 16, 1996														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBIN D. ANDERSON TOWER 110 600 N. WOLFE ST BALTIMORE MD 21287																						
31. Date filed (Month, Day, Year) APR 18 1996				32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12260

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Reed Curtis</b>				2. Date of Death Month <b>April</b> Day <b>15</b> Year <b>1996</b>		3. Time of Death <b>1130 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1556 Fairmount Road</b>				4b. City, Town, or Location of Death <b>Hampstead</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>218-24-7757</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 25, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1556 Fairmount Road</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>				16b. Kind of Business/Industry <b>C&amp;P Telephone Co</b>	
	17. Father's Name (First, Middle, Last) <b>Paul Reed</b>				16. Mother's Name (First, Middle, Maiden Surname) <b>Maxine Shamer</b>			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Jeffrey L. Curtis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4204 Upper Beckleysville Rd, Hampstead, MD 21074</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shiloh Cemetery</b>		Date <b>4/19</b>		20c. Location - City or Town, State <b>Hampstead, Md</b>	
	21. Signature of Funeral Service Licensee <b>Steven W. Eline</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St, Hampstead, MD 21074</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dehydration</b> Due to (or as a consequence of): <b>b. Progressive Spinocerebellar Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of Cerebral Vascular accident ..</b>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>W. H. F. and MD</b>		29c. License number <b>DO 2386</b>		29d. Date signed (Month, Day, Year) <b>4/15/1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W H F. and MD 3223 MAIN ST, MANCHESTER, MD 21102</b>								
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>		32. Registrar's Signature <b>J. A. Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and all

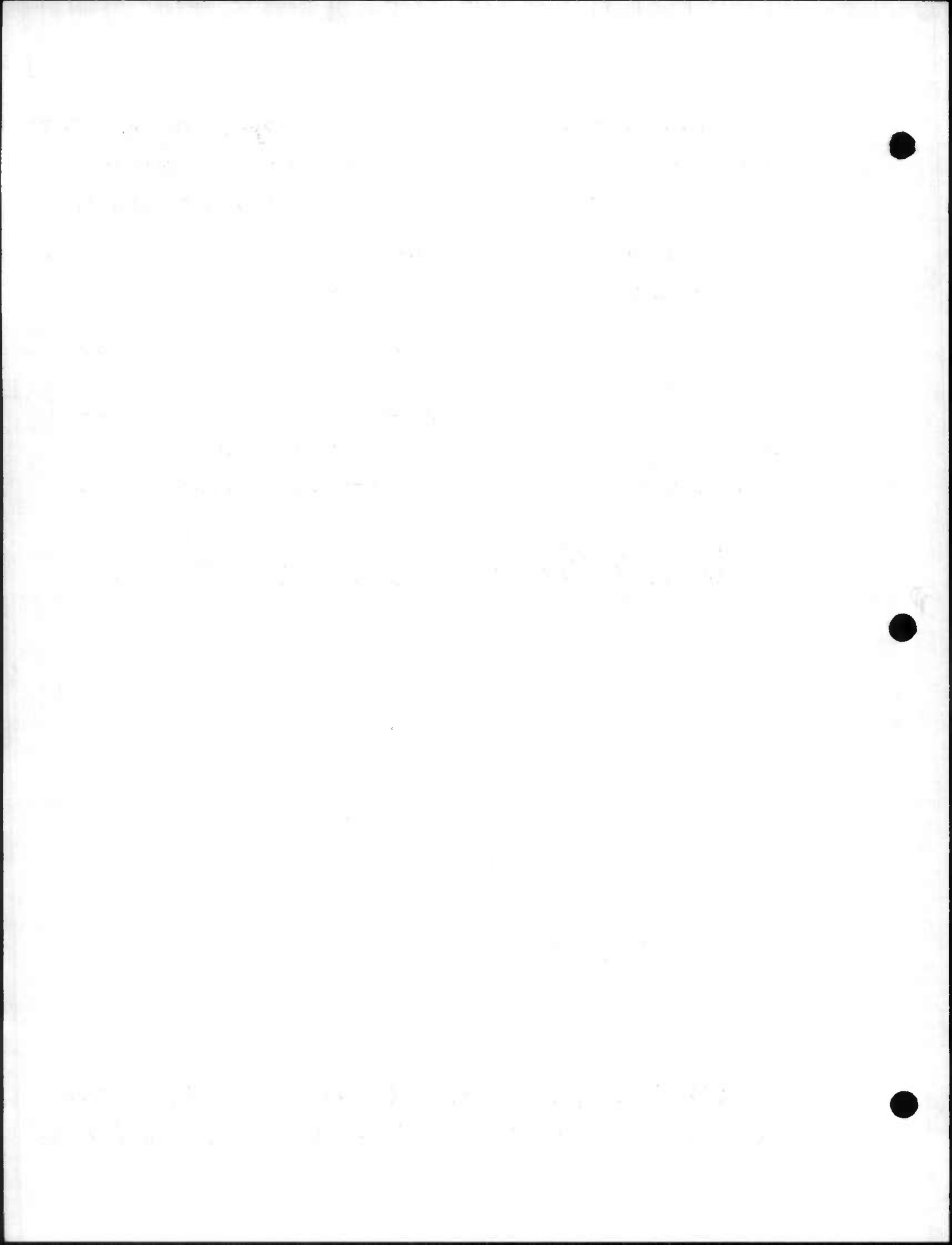
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12261

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROGER C. CHRISTOPHER</b>		2. Date of Death Month <b>April</b> Day <b>10</b> Year <b>1996</b>		3. Time of Death <b>0544</b>
	4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>220-32-8546</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months <b>09</b> Days <b>19</b>	8. Date of Birth (Month, Day, Year) <b>09-19-1928</b>
	9. Birthplace (State or Foreign Country) <b>MD</b>				
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>EDEN</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>543 RT1</b>		10f. Zip Code <b>21822</b>		10g. Citizen of What Country? <b>US</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		17. Kind of Business/Industry <b>TRUCK DRIVER</b>
	18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				
	19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				
	19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				
	19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) <b>ERNEST Christopher</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY WRIGHT</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>MARY Christopher / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30411 Spruce St. Princess Anne, MD. 21853</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wright's Cemetery</b>		20c. Location - City or Town, State <b>EDEN, MD</b>
	21. Signature of Funeral Service Licensee <i>Anthony E. Ward</i>		22. Name and Address of Facility <b>ANTHONY E. WARD Funeral Home</b> <b>30639 HAMPTON AVE</b> <b>Princess Anne, MD. 21853</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardio gene Shock</b>		Approximate Interval Between Onset and Death <b>Two yr</b>		
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Refractory CHT</b>				
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b>				
	23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	23e. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	23f. Part VI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>4/10/96</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Joseph Raffetto</i>					
29c. License number <b>20441</b>					
29d. Date signed (Month, Day, Year) <b>4/10/96</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH RAFFETTO, MD 403 QUINCY ST SALISBURY, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>					
32. Registrar's Signature <i>James A. ...</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 12262

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12263

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAURICE</b>				2. Date of Death Month <b>APRIL</b> Day <b>5</b> Year <b>1996</b>				3. Time of Death <b>10:45 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY SHOCK TRAUMA UNIT</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>-----</b>	
Funeral Director	5. Social Security Number <b>352-03-2995</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 29, 1918</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>		
	Usual Residence of Decedent									
10a. State <b>North Carolina</b>		10b. County <b>Brunswick</b>		10c. City, Town or Location <b>Calabash</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1026 High Point Avenue, S.W.</b>				10f. Zip Code <b>28467</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Twelve Years</b> College (1-4 or 5+) <b>-----</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Refrigerator Repairman</b>			16b. Kind of Business/Industry <b>Self-Employed</b>			
17. Father's Name (First, Middle, Last) <b>Edwin E. Cook</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Montimer</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Son: Steve Cook</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Raimond Street, Yaphank, New York 11980</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calverton National Cemetery</b>		Date <b>4/9/96</b>		20c. Location - City or Town, State <b>Calverton, New York</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>4-5-96</b>		28b. Time of Injury <b>1744 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>passenger in car involved in motor vehicle collision</b>		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Perryville, Cecil Co Md</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i> <b>Dennis J. Chute MD</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 6, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>APR 10 1996</b>				32. Registrar's Signature <i>[Signature]</i> <b>John Davidson Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12264

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Alexander Curry</i>				2. Date of Death Month <i>April</i> Day <i>11</i> Year <i>1996</i>		3. Time of Death <i>10:17 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Baltimore Veterans Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>219-07-2506</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb. 3, 1921</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Cecil</i>		10c. City, Town or Location <i>Perryville</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>205 Concord Drive</i>				10f. Zip Code <i>21903</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) Six Years</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Welder</i>		16b. Kind of Business/Industry <i>Wiley Manufacturing Co. Port Deposit, Maryland</i>		
17. Father's Name (First, Middle, Last) <i>William H. Curry</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ella Billingsley</i>				
19a. Informant's Name/Relationship (Type, Print) <i>N. Richard Curry (Son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4661 Mirabella Ct., St. Petersburg, Florida 33706</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>R.A.Ferris &amp; Company</i>		Date <i>4/15/96</i>		20c. Location - City or Town, State <i>West Chester, Pennsylvania</i>		
21. Signature of Funeral Service Licensee <i>Thomas M. Patterson, Sr.</i>				22. Name and Address of Facility <i>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Lung cancer, unresectable</i> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death <i>2 years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i> <i>Myocardial Infarction</i> <i>COPD, Repair of strangulated inguinal hernia</i>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Seth Winters MD</i>		29c. License number <i>D48088</i>		29d. Date signed (Month, Day, Year) <i>4/16/96</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Molly Buzdon MD, 10 N. Greene St. Baltimore VA Hosp, Baltimore MD</i>								
31. Date filed (Month, Day, Year) <i>APR 12 1996</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 12265

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>PETER ALLEN CARLTON</b>			2. Date of Death Month <b>April</b> Day <b>03</b> Year <b>1996</b>		3. Time of Death <b>4:54pm</b>		
4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>		
5. Social Security Number <b>215-36-4831</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 29 1941</b>	
9. Birthplace (State or Foreign Country) <b>New York</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Clarksburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>24800 Stringtown Road</b>			10f. Zip Code <b>20871</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1960/63</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Self employed</b>		
17. Father's Name (First, Middle, Last) <b>Harold O. Carlton</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Allen</b>				
19a. Informant's Name/Relationship (Type, Print) <b>wife</b> <b>Arlene Davis Carlton</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24800 Stringtown Rd. Clarksburg, MD 20871</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's</b>		20c. Date <b>4/6/96</b>		20d. Location - City or Town, State <b>Barnesville, MD</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Hilton Funeral Home Barnesville, MD 20838</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Coronary Arrest</b> Due to (or as a consequence of): b. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>Minutes</b> <b>Minutes</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 			29c. License number <b>D32045</b>		29d. Date signed (Month, Day, Year) <b>April 03, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patrick Crarey 9901 Medical Center Drive, Rockville, MD 20850</b>							
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>							
32. Registrar Signature 							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12266

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Blanche Louise Coffman			2. Date of Death Month 31 Day 1996 Year		3. Time of Death 1:52 A:M	
	4e. Facility Name (If not institution, give street and number) Physicians Memorial Hospital			4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 234-18-5532		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 1/6/16
	9. Birthplace (State or Foreign Country) Brunswick MD		10a. State WV		10b. County Cabell		10c. City, Town or Location Huntington
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 169 Oakland Avenue		10f. Zip Code 25702		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaker		
	17. Father's Name (First, Middle, Last) Daniel Webster Keyser			18. Mother's Name (First, Middle, Maiden Surname) Annie Bannard			
	19a. Informant's Name/Relationship (Type, Print) Eugene L. Coffman, Jr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9579 Randall Drive, White Plains, MD 20695			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Old Brethren Cemetery 4/4		20c. Location - City or Town, State Brownsville MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ives-Pearson Funeral Homes Arlington, VA 22201			
	23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Atherosclerosis  Approximate Interval Between Onset and Death 46min						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, cerebrovascular accident, Renal failure, congestive heart failure, Hypercholesterolemia						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number D-08370		29d. Date signed (Month, Day, Year) 3/31/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Pritchett MD 118 LaGrange Avenue P.O. Box 1317 LaPlata Md. 20646							
31. Date filed (Month, Day, Year) APR 1 1 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



96 12267

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY JOANNE CULLINANE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>March 27, 1996</b>		3. TIME OF DEATH <b>8:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-50-3599</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 10, 1938</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Myersville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4219 Fishers Hollow Road</b>				10f. ZIP CODE <b>21773</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receptionist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert G. Saffran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Sue Cady</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Daniel F. Cullinane</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4219 Fishers Hollow Road, Myersville, MD 21773</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Brethren Cemetery 4/1</b>		20c. LOCATION — City or Town, State <b>Myersville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>massive pulmonary embolism</b> DUE TO (OR AS A CONSEQUENCE OF): <b>post surgical</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>post surgical</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> D.O.A. <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D15804</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-29-96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Steven A. Pickert, MD 180 Thomas Johnson Drive, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 29 1996</b>		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Campbell Lorraine

96 12268

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lorraine Gladys Campbell				2. DATE OF DEATH April 6 DAY 1996		3. TIME OF DEATH 12:27P M	
4. SOCIAL SECURITY NUMBER 579-66-5421		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	7. DATE OF BIRTH (Month, Day, Year) 02/26/36		8. BIRTHPLACE (State or Foreign Country) D.C.	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring, MD.		9c. COUNTY OF DEATH Montgomery Co.	
10a. STATE D.C.				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Washington	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 537 24th Street, N.E.		10f. ZIP CODE 20002	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper				16b. KIND OF BUSINESS/INDUSTRY Domestic/Private		17. FATHER'S NAME (First, Middle, Last) Robert Proctor	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Dosie Holly				19a. INFORMANT'S NAME (Type/Print) Joseph E. Campbell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 537 24th Street, N.E. Washington, D.C. 20002	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Cemetery 4/11		20c. LOCATION — City or Town, State Landover, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY ROBERT G. MASON FUNERAL HOME 1661 GOOD HOPE ROAD, SE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>breast cancer</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Metastasis to bones &amp; liver</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. - FACP N. Farr				29c. LICENSE NUMBER D32247		29d. DATE SIGNED (Month, Day, Year) 4.6.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. FARR M.D. 501 N. Frederick Ave. Gaithersburg							
31. DATE FILED (Month, Day, Year) APR 12 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12269

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DELIA H. CLEMMONS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MARCH 25, 1996</b>		3. TIME OF DEATH <b>5:20 PM</b>	
4. SOCIAL SECURITY NUMBER <b>196-26-7029</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>103 YRS.</b>	7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 25, 1893</b>		8. BIRTHPLACE (State or Foreign Country) <b>MORGANZA, MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>REGENCY NURSING CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FORESTVILLE</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10a. STATE <b>MD</b>				10b. CITY, TOWN OR LOCATION <b>PRINCE GEORGE'S</b>		10c. CITY, TOWN OR LOCATION <b>FORESTVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7420 MARLBORO PIKE</b>		10f. ZIP CODE <b>20747</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b></b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEKEEPER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC(PVT.)</b>		17. FATHER'S NAME (First, Middle, Last) <b>JAMES HENRY HALL</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA THOMAS</b>				19a. INFORMANT'S NAME (Type/Print) <b>MARY HALL WATSON/ SISTER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1724 V. ST. NW WASHINGTON, DC 20009</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY 4/2/96</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i>				22. NAME AND ADDRESS OF FACILITY <b>MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death <b>1 WEEK</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William T. Tanner</i>				29c. LICENSE NUMBER <b>D35206</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/27/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM T. TANNER, MD 11701 LIVINGSTON RD. FORT WASHINGTON, MD 20745</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>				32. REGISTRAR'S SIGNATURE <i>John Shuster</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

APR 30 1994  
FBI - NEW YORK



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12270

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KENNETH ANTONIO CLAY

2. Date of Death  
Month Day Year  
MARCH 10, 19963. Time of Death  
11:16am

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director5. Social Security Number  
226-86-11726. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
34 Yrs.8. Date of Birth  
(Month, Day, Year)  
OCT. 7, 19619. Birthplace (State or Foreign Country)  
WASH., DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

FORT WASHINGTON

10d. Inside City Limits  
☒ Yes ☐ No

10e. Street and Number

2701 BEY COURT

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Dates  
5/7/82 - 11/24/8213. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) Collega (1-4 or 5+)

12th

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
COUNSELOR16b. Kind of Business/Industry  
COMMUNITY CONNECTIONS  
PRIVATE

17. Father's Name (First, Middle, Last)

JOHN D. CLAY

18. Mother's Name (First, Middle, Maiden Surname)

CAROLYN HAMMOND

19a. Informant's Name/Relationship (Type, Print)

CAROLYN H. MCKENZIE/ MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2701 BEY CT. FORT WASHINGTON, MD 20744

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
WASHINGTON NATIONAL CEM.

Date

3/15/96

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Juawana L. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME  
4308 SUITLAND RD. SUITLAND, MD 2074623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acquired Immuno-Deficiency Syndrome  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

years.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient☒ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D25925

29d. Date signed (Month, Day, Year)

March 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD # 205, 7720 Wisconsin Ave, Bethesda md 20814

31. Date filed (Month, Day, Year)

MAR 15 1996

32. Registrar's Signature

John Anderson

State  
Registrar

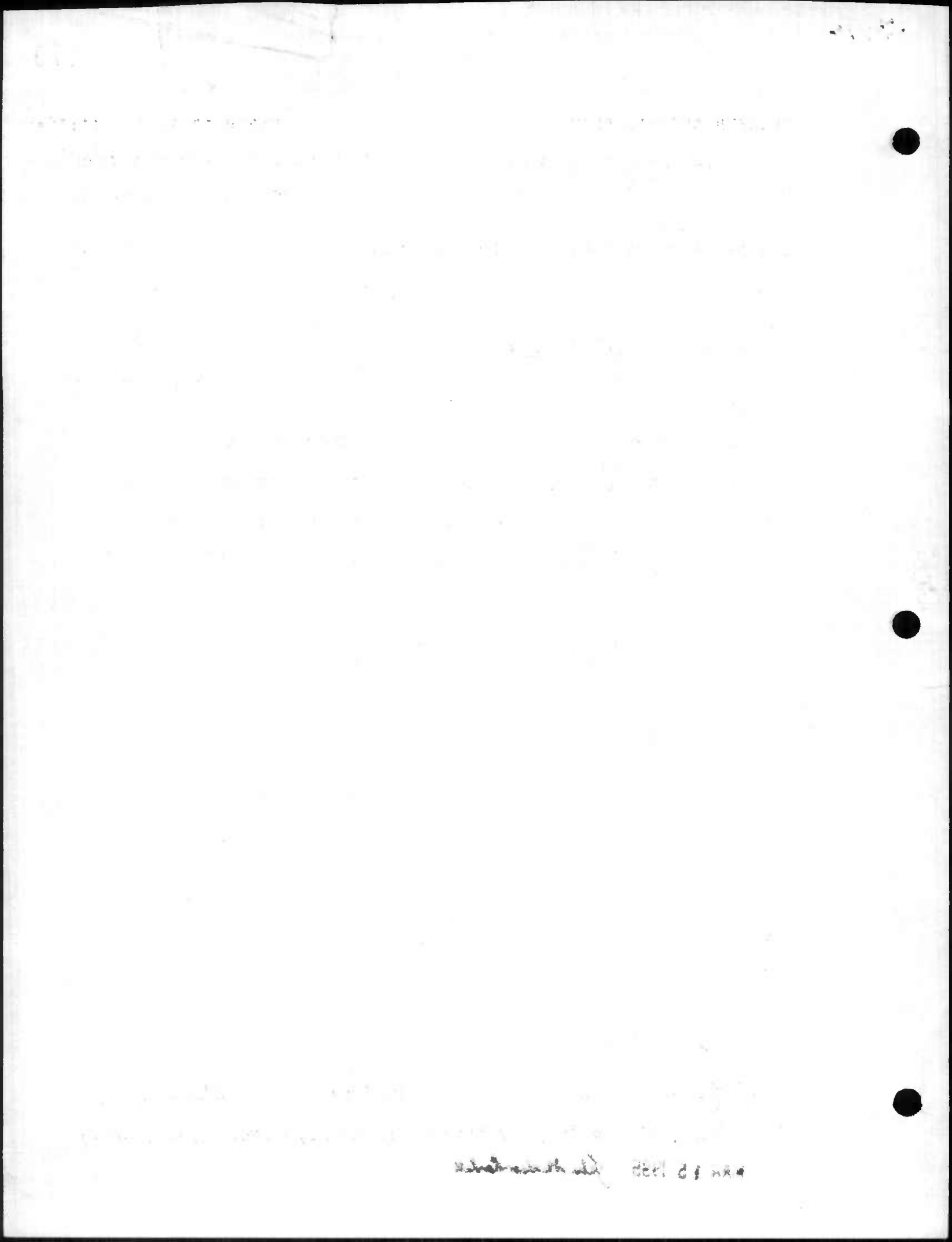
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



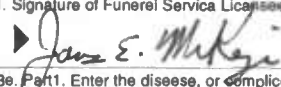
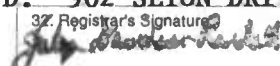
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12271

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET ELIZABETH DAVIS</b>				2. Date of Death Month Day Year <b>APRIL 7, 1996</b>		3. Time of Death <b>08:25 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>213-22-2767</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 30, 1923</b>	9. Birthplace (State or Foreign County) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Lonaconing</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>69 Douglas Avenue</b>				10f. Zip Code <b>21539</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Wesley Duckworth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Elizabeth Douglas</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Lamberson-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16012 Rockville St. SW, Lonaconing, Md. 21539</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. View Cemetery</b>		Date <b>April 9, 1996</b>		20c. Location - City or Town, State <b>Moscow Mills, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>CEREBRAL INSUFFICIENCY - CVA</b> Due to (or as a consequence of): <b>ARTERIAL EMBOLISM</b>  b. Due to (or as a consequence of): <b>CARDIAC ARRHYTHMIA</b>  c. Due to (or as a consequence of): <b>ARTERIOSCLEROTIC HEART DISEASE</b>  d.  Approximate Interval Between Onset and Death <b>30 MINUTES</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RETROPERITONEAL BLEEDING</b>  <b>COAGULOPATHY</b>  <b>SEPSIS</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident investigation 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be 4 <input type="checkbox"/> Homicide determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D23167</b>		29d. Date signed (Month, Day, Year) <b>APRIL 7, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JUAN A ARRISUENO, M.D. 902 SETON DRIVE CUMBERLAND MD 21502</b>									
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12272

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS JEAN DAUGHERTY</b>				2. Date of Death Month Day Year <b>APRIL 8 1996</b>		3. Time of Death <b>7:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>217-30-1784</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 2, 1935</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10e. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits X 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>518 Marietta Street</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married X 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Ret. Office Manager</b>		16b. Kind of Business/Industry <b>C &amp; P Telephone Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Dominick Zimmino</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary (DeLuca)</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mervin Daugherty--son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24 Mount Pleasant Avenue; Easton, MD 21601</b>	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State X 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WVU Anatomical Board</b>		20c. Location - City or Town, State <b>04/10 Morgantown, WV</b>		20d. Date	
	21. Signature of Funeral Service Licensee <b>James J. Scarpelli</b>		22. Name and Address of Facility <b>Scarpelli Funeral Home Cumberland, MD 21502</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>EMBOIC CEREBRAL VASCULAR ACCIDENT</b>		Approximate Interval Between Onset and Death <b>SIX HOURS</b>	
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADENOCARCINOMA OF RIGHT LUNG</b> <b>ATRIAL FIBRILLATION</b> <b>DIABETES MELLITUS</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day, Year) <b>M</b>	
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>James J. Scarpelli</b>		29c. License number <b>D33417 (MD)</b>		29d. Date signed (Month, Day, Year) <b>APRIL 9, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES R. MOEN, MD 1065 NATIONAL HIGHWAY LAVALLE, MARYLAND 21002</b>		31. Date filed (Month, Day, Year) <b>APR 11 1996</b>		32. Registrar's Signature <b>John J. [Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12273

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY EMMA DIEHL</b>				2. Date of Death Month <b>APRIL</b> Day <b>3</b> Year <b>1996</b>		3. Time of Death <b>12:00 noon</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>218-34-4284</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 7, 1906</b>	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>
	Usual Residence of Decedent							
10a. State <b>PA</b>		10b. County <b>BEDFORD</b>		10c. City, Town or Location <b>BUFFALO MILLS</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>R. D. 1, BOX 205</b>				10f. Zip Code <b>15534</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>		
17. Father's Name (First, Middle, Last) <b>WINFIELD SCOTT SHAFFER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA MILLER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MAYNARD D. DIEHL</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>R. D. 1, BOX 206, BUFFALO MILLS, PA 15534</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HYNDMAN CEMETERY</b>		Date <b>APRIL 6, 1996</b>		20c. Location - City or Town, State <b>HYNDMAN, PA 15545</b>	
21. Signature of Funeral Service Licensee <i>Harvey H. Zeigler</i>				22. Name and Address of Facility <b>HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Endstage Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Ischemic Myocardioyathy</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>2 mos</b> <b>3 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Dr. J. J. Wagner</i>			29c. License number <b>D22181</b>		29d. Date signed (Month, Day, Year) <b>APRIL 4 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary Wagner, M.D. 945 Bishop Walsh Road Cumberland, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>APR 04 1996</b>			32. Registrar's Signature <i>J. J. Wagner</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar






**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12274

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Gertrude P. Donovan</b>					2. Date of Death Month <b>April</b> Day <b>11</b> Year <b>1996</b>		3. Time of Death <b>10:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>					4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
<b>Funeral Director</b>	5. Social Security Number <b>217-10-8305</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 1, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>			10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>Crusader Arms Apts. Apt. 103, 218 Meteor Avenue</b>					10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collage (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business/Industry <b>Garment</b>	
17. Father's Name (First, Middle, Last) <b>Augustus Ellsworth Phillips</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Aaron</b>				
19a. Informant's Name/Relationship (Type, Print) <b>step-daughter</b> <b>Joan D. Banning</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 37, Linkwood, MD. 21835</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Mem Pk</b>		Data <b>4-14</b>		20c. Location - City or Town, State <b>Cambridge, MD.</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>Immediate Cause (Final disease or condition resulting in death)</b> <b>Acute Subarachnoid Hemorrhage</b></p> <p>Due to (or as a consequence of):</p> <p><b>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b></p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%;"> <p><b>Approximate Interval Between Onset and Death</b> <b>1 day</b></p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerosis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number <b>D-2P209</b>		29d. Date signed (Month, Day, Year) <b>April 11, 1996</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Edmund J. MacLaughlin 4 Aurora St. Cambridge, Md 21613</b>									
31. Date filed (Month, Day, Year) <b>APR 15 1996</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12275

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>CLIFTON William DeFORD</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>12</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>10:30</u> M	
4. SOCIAL SECURITY NUMBER <u>219-03-2123</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>95</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>JAN. 24, 1901</u>	
8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>				9a. FACILITY NAME (If not institution, give street and number) <u>STELLA MARIS HOSPICE</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>TOWSON</u>	
9c. COUNTY OF DEATH <u>BALTIMORE</u>				10a. STATE <u>MARYLAND</u>			
10b. COUNTY <u>CARROLL</u>				10c. CITY, TOWN OR LOCATION <u>WESTMINSTER</u>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>2000 REESE RD.</u>			
10f. ZIP CODE <u>21157</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>CRANE OPERATOR</u>		16b. KIND OF BUSINESS/INDUSTRY <u>MANUFACTURING</u>			
17. FATHER'S NAME (First, Middle, Last) <u>THOMAS CHARLES DeFORD</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>FANNIE DAVIS</u>			
19a. INFORMANT'S NAME (Type/Print) <u>CALVIN D. DeFORD</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2006 REESE RD., WESTMINSTER, MD. 21157</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>CARROLLTON CHURCH OF GOD</u> <u>4/15</u> DATE		20c. LOCATION — City or Town, State <u>FINKSBURG, MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>FLETCHER FUNERAL HOME</u> <u>254 E. MAIN ST., WESTMINSTER, MD. 21157</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>BLADDER CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <u>1 year</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u>		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>15584</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/14/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>EDDIE NAKHODA M.D.</u>							
31. DATE FILED (Month, Day, Year) <u>APR 15 1996</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12276

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>RUTH CUTSAIL DERR</b>				2. Date of Death Month <b>April</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>5:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1665 Shookstown Road</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
<b>Funeral Director</b>	5. Social Security Number <b>213- 40- 3176</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 8, 1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1665 Shookstown Road</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>—</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		18b. Kind of Business/Industry <b>self</b>		
17. Father's Name (First, Middle, Last) <b>Andrew Creager</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Himes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Myron Z. Derr / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2604 Marker Road, Middletown, Maryland 21769</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>4/9/96</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Atherosclerotic Cardiovascular disease</i> 10 years</b> Due to (or as a consequence of):  <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D35183</b>		29d. Date signed (Month, Day, Year) <b>4/5/96</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Ali J. Afrookteh, M.D. 300 West Ninth Street Frederick, MD 21701</b>								
31. Date filed (Month, Day, Year) <b>APR 08 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12277

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>John Joseph Dougherty</b>						2. Date of Death Month Day Year <b>March 31, 1996</b>		3. Time of Death <b>6:47 pm</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Frederick Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
<b>Funeral Director</b>	5. Social Security Number <b>163-16-5023</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 8, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Walkersville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>134 Challedon Drive</b>				10f. Zip Code <b>21793</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1932 - 1937</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collage (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Safety Program Administrator</b>			16b. Kind of Business/Industry <b>Naval Aviation Supply</b>				
17. Father's Name (First, Middle, Last) <b>John H DOUGHERTY</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Agnes McKEOWN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Dennis J. Dougherty / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>134 Challedon Drive, Walkersville, MD 21793</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Mem Gardens Apr 5, 1996</b>		20c. Location - City or Town, State <b>Frederick, MD</b>					
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MO0706</b>						22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, Maryland 21701</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CVA -</b> Due to (or as a consequence of):  <b>b. </b> Due to (or as a consequence of):  <b>c. </b> Due to (or as a consequence of):  <b>d. </b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>										Approximate Interval Between Onset and Death <b>48 hours</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown					
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how Injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>						29c. License number <b>D-13971</b>		29d. Date signed (Month, Day, Year) <b>3/31/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>											
31. Date filed (Month, Day, Year) <b>APR 04 1996</b>			32. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

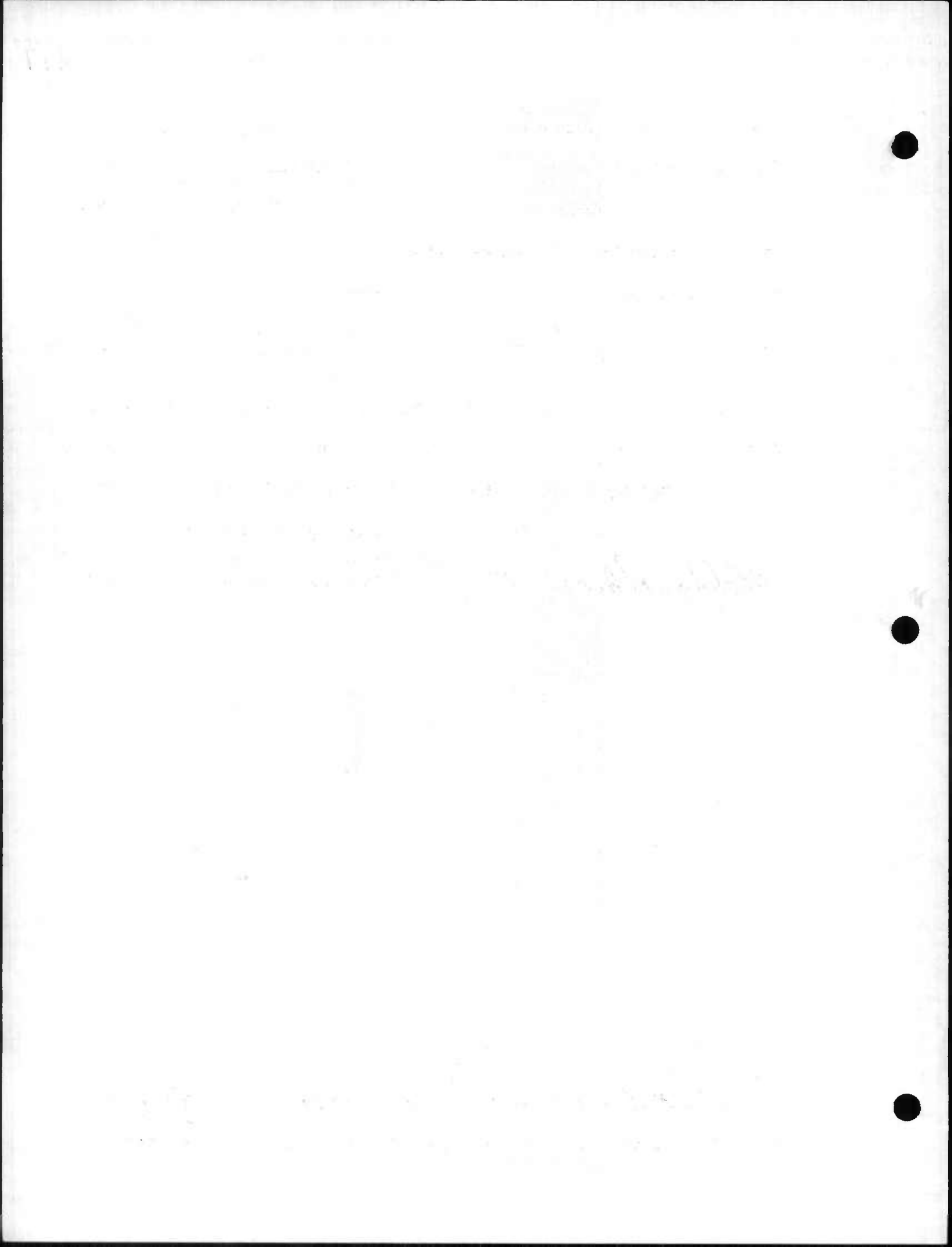
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar

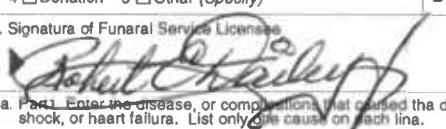
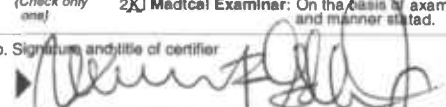
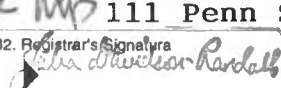




**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96-12278

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>JOHN WALDEMAR DREESSEN</b>					2. Date of Death Month Day Year <b>MARCH 24, 1996</b>		3. Time of Death <b>14:53 P</b>	
	4a. Facility Name (If not Institution, give street and number) <b>5820 ROSEBAY CT.</b>					4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>FREDERICK</b>	
<b>Funeral Director</b>	5. Social Security Number <b>215-38-7706</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 15, 1936</b>		9. Birthplace (State or Foreign Country) <b>D.C.</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5820 Rosebay Court</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Peacetime</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>None</b>		
17. Father's Name (First, Middle, Last) <b>Waldemar C. Dreessen</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Frances Jeanne McCleary</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary D. Sears</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17240 Edwards Ferry Road, Poolesville, MD 20837</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Joseph's Cemetery</b>		Date <b>3/29</b>		20c. Location - City or Town, State <b>Buckeystown, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death) a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death <b>yno</b></p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>MARCH 25, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. Goulet JR MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>MAR 26 1996</b>			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



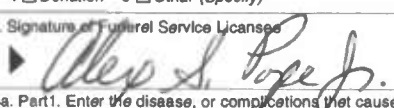
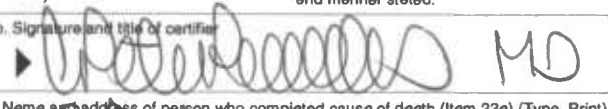
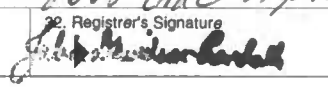
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12279

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Ann Davis-Hill</b>				2. Date of Death Month <b>April</b> Day <b>7</b> Year <b>1996</b>		3. Time of Death <b>4:50 pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>578-72-0276</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>43</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 12, 1952</b>		9. Birthplace (State or Foreign Country) <b>Wash., D.C.</b>	
	Usual Residence of Decedent									
10a. State <b>N/A</b>			10b. County <b>N/A</b>		10c. City, Town or Location <b>WASHINGTON, D.C.</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3730 First St., S.E. #103</b>					10f. Zip Code <b>20032</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ACCOUNTING TECHNICIAN</b>			16b. Kind of Business/Industry <b>U.S. GOVERNMENT</b>			
17. Father's Name (First, Middle, Last) <b>ALLEN DAVIS, JR.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARY W. CLARK</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MARY DAVIS (mother)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>904 Hamlin Street, N.E. Washington, D.C. 20017</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Date <b>4/13/96</b>		20c. Location - City or Town, State <b>LANDOVER, MARYLAND</b>		
21. Signature of Funeral Service Licensee  <b>M859</b>				22. Name and Address of Facility <b>ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 20747</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. acute cerebrovascular accident</b> Due to (or as a consequence of): <b>b. sickle cell disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No  Approximate Interval Between Onset and Death <b>2 hrs</b> <b>lifelong</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  28a. Date of Injury (Month, Day Year)  28b. Time of Injury <b>M</b>  28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  28d. Describe how injury occurred  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  <b>MD</b>  29c. License number <b>D 21531</b>  29d. Date signed (Month, Day, Year) <b>Apr. 8, 1996</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Peter B. ... 5600 Old Georgetown Rd Bethesda, Md</b>										
31. Date filed (Month, Day, Year) <b>APR 12 1996</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



96 12280

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Willie Dixon</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>9</i> YEAR <i>96</i>		3. TIME OF DEATH <i>9:45 AM</i>	
4. SOCIAL SECURITY NUMBER <i>579-01-8202</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>91</i> YRS.		7. DATE OF BIRTH <i>7/24/04</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>EVELYN'S NURSING HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SILVER SPRING</i>		9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
10a. STATE <i>DC</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>WASHINGTON</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>6203 PINEY BRANCH ROAD</i>			
10f. ZIP CODE <i>20011</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2Yrs</i> College (1-4 or 5+) <i>2 Yrs(Trade School) (Federal Government)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Governmental</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Governmental</i>			
17. FATHER'S NAME (First, Middle, Last) <i>WILSON BUTLER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MATTIE MCGUIRE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MRS. MARY G. MILES</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1355 TEWKSBURY PLACE NW, WASHINGTON, DC 20012</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington National</i>		DATE <i>4/22/96</i>		20c. LOCATION — City or Town, State <i>Arlington, Va.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Plummer</i> #318				22. NAME AND ADDRESS OF FACILITY <i>John T. Rhines Co., Inc. 3030 12th St NE, DC 20017</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Alzheimer's Disease</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Rhines</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 9 96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. Rhines</i> <i>8218 Wisconsin Ave</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1996</i>				32. REGISTRAR'S SIGNATURE <i>John T. Rhines</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1971  
2-2-71

~~Handwritten text~~ Best 5/1/76

## Certificate of Death

Reg. No.

96 12281

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES F. DIXON

2. Date of Death

Month Day Year  
APRIL 4, 1996

3. Time of Death

3:06 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER E.R.

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

560-77-9454

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

17

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 8, 1978

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

NA

10b. County

NA

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2108 H St., N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No  
Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

James Franklin Dixon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ju Ha Inge

19a. Informant's Name/Relationship (Type, Print)

Mollie Dixon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2108 H Street, N.E., Washington, D.C. 20002

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

4/11/96

20c. Location - City or Town, State

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 Marlboro Pike, Forestville, Md 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chest injury

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide☐ Pending☐ Investigation☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)  
4-4-96

28b. Time of

injury  
0215M

28c. Injury at

work?

☐ Yes ☒ No

28d. Describe how injury occurred

PEDESTRIAN STRUCK BY CAR

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

STREET

28b. Location (Street and Number or Rural Route Number,  
City or Town, State)  
MARTIN LUTHER KING HWY, P.G. Co.29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL 04, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

J. L. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

0-97 2 0 292



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12282

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Leroy Eyler				2. Date of Death Month Day Year March 29, 1996		3. Time of Death 1:30AM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 214-32-4130	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 31, 1936	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 7163 Canterbury Ct.		10f. Zip Code 21703		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 50's		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Food Service				
	17. Father's Name (First, Middle, Last) Charles Fred Eyler				18. Mother's Name (First, Middle, Maiden Surname) Helen May Mackley				
	19a. Informant's Name/Relationship (Type, Print) Shirley Ann Eyler				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7163 Canterbury Ct, Frederick, MD 21703				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State Hagerstown MD		20d. Date 3/30		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Home 1621 Crossmontown Pk., Frederick, MD 21702						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Cor Pulmonale Due to (or as a consequence of): b. Terminal COPD Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. i) Atrial Fibrillation ii) Ischemic Heart Disease						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D07186		29d. Date signed (Month, Day, Year) 3/29/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Philip Shapiro / 814 Toll House Ave Frederick, MD 21701									
31. Date filed (Month, Day, Year) APR 01 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



t.t

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT DOUGLAS ERNST</b>				2. Date of Death Month Day Year <b>APRIL 06, 1996</b>		3. Time of Death <b>1303PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>LAUREL</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>218-88-5212</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>33</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6-4-1962</b>	9. Birthplace (State or Foreign Country) <b>Connecticut</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3401 Hampstead Mexico Rd.</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collegia (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>None</b>				16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) <b>Douglas D. Ernst</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary B. Branan</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary B. Ernst (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3401 Hampstead Mexico Rd. Hampstead, MD</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremations</b>		Data <b>4/12</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eline Funeral Home 934 S. Main St. Hampstead, MD 21074</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEIZURES</b> a. Due to (or as a consequence of): <b>CLOZARIL INTOXICATION</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>UNKNOWN</b>		28b. Time of injury <b>UNKNOWN</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 10, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>APR 16 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12284

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER EVANS FAZENBAKER</b>				2. Date of Death Month Day Year <b>APRIL 6, 1996</b>		3. Time of Death <b>2030</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>216-07-8886</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 23 1910</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>WV</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Keyser</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1065 Carolina Ave.</b>				10f. Zip Code <b>26726</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrician, Westvaco Corp.</b>		16b. Kind of Business/Industry <b>Paper Manufacture</b>		
17. Father's Name (First, Middle, Last) <b>James Edward Fazenbaker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Evans</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lola Fazenbaker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1065 Carolina Ave. Keyser, WV. 26726</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Philos Cemetery</b>		Date <b>4-8-96</b>		20c. Location - City or Town, State <b>Westernport, Md.</b>		
21. Signature of Funeral Service Licensee <i>Wayne Boal</i>				22. Name and Address of Facility <b>Boal Funeral Home</b> <b>111 Church St. Westernport, Md.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Respiratory failure</b> Due to (or as a consequence of): <b>pneumonia</b> Due to (or as a consequence of): <b>congestive heart failure</b> Due to (or as a consequence of): <b>coronary artery disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Cerebral infarct</b> <b>Bilateral abraded knee amputation</b> <b>Permanent pacemaker</b>								Approximate Interval Between Onset and Death <b>8 days</b> <b>7 days</b> <b>2 years</b> <b>8 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral infarct</b> <b>Bilateral abraded knee amputation</b> <b>Permanent pacemaker</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D15463</b>		29d. Date signed (Month, Day, Year) <b>APRIL 7, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shin Kim, M.D. 90 Main Street Westernport, MD 21562</b>								
31. Date filed (Month, Day, Year) <b>APR 10 1996</b> Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12285

Amended # 2, 4/4/96, N.H.S. Allegany County  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NELSON RAY FLEMING</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>29</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>12:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>226-78-3217</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>41</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Oct 4, 1954</b>		8. BIRTHPLACE (State or Foreign Country) <b>VA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Burlington</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 1 Box 186 C</b>				10f. ZIP CODE <b>26710</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman--Serviceman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Truck Enterprises, Inc.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Fleming, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Lantz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lana E. Fleming</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 186 C; Burlington, WV 26710</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Linville Creek Cemetery 04/02</b>		20c. LOCATION — City or Town, State <b>Broadway, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jones F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Cancer of Lungs</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M.D.</b>				29c. LICENSE NUMBER <b>D48143</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 30, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. WILSON YAP 902 SETON DRIVE CUMBERLAND, MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1996</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12286

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beatrice Lucille Flynn				2. DATE OF DEATH MONTH DAY YEAR April 9, 1996		3. TIME OF DEATH 2:00 A M	
4. SOCIAL SECURITY NUMBER 234-10-6029		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 11, 1911	
8. BIRTHPLACE (State or Foreign Country) WV		9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Home Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT				10a. STATE MD		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER Decatur Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY G.C. Murphy Co.			
17. FATHER'S NAME (First, Middle, Last) Dana W. Feather				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jane (Welsh)			
19a. INFORMANT'S NAME (Type/Print) Michael Flynn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18031 Showalter Road; Maugansville, MD 21767			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		DATE 04/11		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Nicholas J. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Recurrent Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 2 wks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Failure Anterior MI Cardiomegaly Sinus Brachyarrhythmia							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Datta MD				29c. LICENSE NUMBER D18017		29d. DATE SIGNED (Month, Day, Year) April 9, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Datta 334 Mill Street; Hagerstown, MD 21740							
31. DATE FILED (Month, Day, Year) APR 12 1996				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12287

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JUSTIN JOSEPH FRANCIS</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>10</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>3:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>025-34-9133</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 10, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1437 Hamilton Blvd.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>	
10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1437 Hamilton Blvd.</b>	
10f. ZIP CODE <b>21742</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 + Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer / Architech</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Peter Fenway Francis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Loretta Lynch</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bertha Elizabeth Francis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1437 Hamilton Blvd. Hagerstown, Maryland 21742</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery April 12, 1996</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				22. NAME AND ADDRESS OF FACILITY <b>Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Md. 21742</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Parkinson's Disease with terminal aspiration pneumonia</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Adenocarcinoma of the Colon one year</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert + Brull MD. Personal Physician</i>				29c. LICENSE NUMBER <b>D04359</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/10/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert + Brull, MD 1459 Potomac Ave Hagerstown MD 21742</b>							
31. DATE FILED (Month, Day, Year) <b>APR 1 01996</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended item #'s 23a &amp; 27

State of Maryland / Department of Health and Mental Hygiene

per O.C.M.E. 4/17/96 Carroll CO. P.L.C.

## Certificate of Death

Reg. No.

96 12288

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN STEWART

FLOWERS

2. Date of Death

Month Day Year  
APRIL 09 1996

3. Time of Death

1:46 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

236-78-9751

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 16, 1958

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 Foxmoor Court

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Director of Reimbursements

16b. Kind of Business/Industry

Integrated Health Services

17. Father's Name (First, Middle, Last)

Edwin F. Flowers

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Ellis

19a. Informant's Name/Relationship (Type, Print)

Edwin F. Flowers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

464 Aspen Street, Morgantown, W.VA 26505

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

4/12

20c. Location - City or Town, State

New Manchester, W VA

21. Signature of Funeral Service Licensee

Steve W. Elmer

22. Name and Address of Facility

Eline Funeral Home

934 S Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cocaine Intoxication

Approximate  
Interval Between  
Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☒ Pending-  
investigation6 ☒ Could not be  
determined26a. Date of Injury  
(Month, Day Year)

4-9-96

26b. Time of  
injury

UNKNOWN

26c. Injury at  
Work?1 ☐ Yes 2 ☒ No

26d. Describe how injury occurred

UNKNOWN

26e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

FOUND IN HOUSE

26f. Location (Street and Number or Rural Route Number,  
City or Town, State)17 MAIN ST.  
OWINGS MILLS, MD.29e. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. CARSON LOCKE, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 09, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. CARSON LOCKE, MD

31. Date filed (Month, Day, Year)

APR 11 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12289

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

WASHINGTON

FORTH JR.

2. Date of Death

Month

Day

Year

APRIL 8, 1996

3. Time of Death

1:55 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

359-22-5816

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 10, 1925

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

5860 Genesis Lane Apt. 418

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: W. W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

commercial artist

16b. Kind of Business/Industry

federal government

17. Father's Name (First, Middle, Last)

George Forth Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Valley Unknown

19a. Informant's Name/Relationship (Type, Print)

Lorraine Hoak (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 3 Box 120-H9 Kearneysville, W.Va. 25430

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resthaven Memorial Gardens 4/12

Data

20c. Location - City or Town, State

Frederick, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

31 E. Main St., Middletown, Md. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE MYELODYSPLASTIC SYNDROME

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

17 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE GASTROINTESTINAL HEMORRHAGE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 31761

29d. Date signed (Month, Day, Year)

4/8/96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

BRIAN M. O'CONNOR MD 501 W. SEVENTH ST., FREDERICK MD 21701

31. Date filed (Month, Day, Year)

APR 10 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





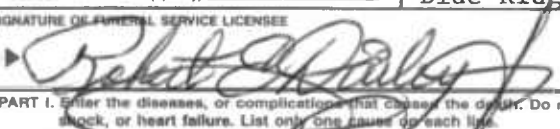

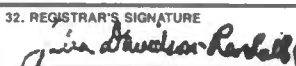
96 12290

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY CATHERINE FLYNN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1996</b>		3. TIME OF DEATH <b>1:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-26-6384</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 23, 1930</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7174 Browns Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Thurmont</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Thurmont</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7174 Browns Lane</b>				10f. ZIP CODE <b>21788</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lawrence Lee Wright</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marcella C. Dowling</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Leonard F. Flynn</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7174 Browns Lane, Thurmont, Maryland 21788</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Blue Ridge Cemetery 4/8</b>		20c. LOCATION — City or Town, State <b>Thurmont, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 615 East Main St. Thurmont, Maryland 21788</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MIXED ADENOSQUAMOUS LUNG CANCER</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>11 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D31761</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/8/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Brian M. O'Connor, MD 501 West Seventh Street, Frederick, Maryland 21701</b>							
31. DATE FILED (Month, Day, Year) <b>APR 08 1996</b>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

APR 08 1958

96 12291

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Patricia Minnie Faith Ettl</b>				2. DATE OF DEATH MONTH <b>March</b> DAY <b>29</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>5:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214-28-0534</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 10, 1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8101 Fingerboard Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Urbana</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Urbana</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8101 Fingerboard Road</b>	
10f. ZIP CODE <b>21704</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Editor/Reporter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Newspaper</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Paul Burlin ROSENCRANTZ, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Moselle BAYARD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Johanna Moselle Ettl, Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8101 Fingerboard Road, Frederick, Maryland 21704</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Smithsburg Crematory, April 1, 1996</b>		20c. LOCATION — City or Town, State <b>Smithsburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard E. Hraf</b> <b>MO0255</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>EXTENSIVE STAGE SMALL CELL LUNG CANCER</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <b>M</b>  28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <b>Brian M. O'Connor</b>  29c. LICENSE NUMBER <b>D 31761</b>  29d. DATE SIGNED (Month, Day, Year) <b>March 29, 1996</b>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Brian M. O'Connor MD 501 West Seventh Street, Frederick, Maryland 21701</b>  31. DATE FILED (Month, Day, Year) <b>APR 01 1996</b>  32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12292

## Certificate of Death

Reg. No.

|   |   |  |  |                                 |   |  |   |   |  |
|---|---|--|--|---------------------------------|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LARRY FRANKLIN</b>   |  |  |                                 | 2. Date of Death<br>Month <b>April</b> Day <b>6</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>4:30AM</b>                                       |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Seton Hill Manor Inc.</b>  |  |  |                                 | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-46-6173</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |                                 | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>2/2/1936</b>                  |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WashingtonDC</b>   |  | 10a. State<br><b>D.C.</b>  |                                 | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Washington</b>                        |   |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>2820 27th Street N.E.</b>  |  | 10f. Zip Code<br><b>20018</b>  |                                 | 10g. Citizen of What Country?<br><b>USA</b>   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |   |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                       |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Disabled</b> |                                 | 16b. Kind of Business/Industry<br><b>none</b>   |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Stanley Franklin</b>  |  |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Peggy P. Cook</b>   |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Beverly White</b>  |  |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>619 Sheridan St, N.W., Wash, DC. 20011</b>    |  |   |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial</b>                            |                                 | Date<br><b>4/11/96</b>  |  | 20c. Location - City or Town, State<br><b>Landover, MD.</b>             |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |                                 | 22. Name and Address of Facility<br><b>Austin Royster Funeral Home</b><br><b>3605 14th St. N.W., Wash, D.C. 20010</b>                             |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Brain tumor</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b><br><b>Renal Insufficiency</b> |  |  |                                 |   |  |   | Approximate Interval Between Onset and Death<br><b>months</b>   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |  |                                 |   |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |                                 |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |                                 |   |  |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No |   | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Medical Examiner  |   | 29b. Signature and title of certifier<br>  |  |                                 |   |  |   |   |  |
| 29c. License number<br><b>D32158</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/9/96</b>   |  |                                 |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jyotin Parikh, 821 North Eutaw Street, Baltimore, MD. 21201</b>      |   |  |  |                                 |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1996</b>   |   |  |  |                                 |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1991 11 24 40

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12293

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |   |  |   |  |
|---|---|---|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>William Ezzell Gamble                       |   |   |   | 2. Date of Death<br>Month Day Year<br>March 27, 1996   |   | 3. Time of Death<br>12:50 p.m.   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>8113 Laurel Ridge Rd. |   |   |   | 4b. City, Town, or Location of Death<br>Frederick  |   | 4c. County of Death<br>Frederick   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>241-46-0617  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>59 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Aug. 19, 1936   | 9. Birthplace (State or Foreign Country)<br>N. Carolina |  |
|   | Usual Residence of Decedent   |   |   |   |  |   |  |   |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Frederick  |   | 10c. City, Town or Location<br>Frederick  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br>8113 Laurel Ridge Rd.   |   |   |   | 10f. Zip Code<br>21702  |  | 10g. Citizen of What Country?<br>United States  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Procurement Specialist   |  |   | 16b. Kind of Business/Industry<br>Bechtel Inc.   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Ezzell William Gamble  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucille Morrow   |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Anastasia Cousins Gamble (wife)   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8113 Laurel Ridge Rd. / Frederick, Maryland 21702  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rowan Memorial park |   | Data<br>4-1-96  |  | 20c. Location - City or Town, State<br>Rowan Co., N. Carolina   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br>Stauffer Funeral Home<br>1621 Opossumtown Pike / Frederick, Md. 21702   |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC ADENOCARCINOMA UNKNOWN PRIMARY<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |  |   |  | Approximate Interval Between Onset and Death<br>3 WEEKS |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HEPATIC FAILURE SECONDARY TO METASTASES   |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 28d. Describe how injury occurred   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D14626 D31761  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br>March 27, 1996   |   |   |   |   |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>P. Gregory Rausch, MD, 501 West 7th Street, Frederick, MD 21701   |   |   |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 02 1996  |   |   |   | 32. Registrar's Signature<br>  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 12294

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Norma Jean Gordon</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 6 1996</i>   |  | 3. TIME OF DEATH<br>M<br><i>6:45AM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-92-0886</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>34</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Nov 9 1961</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Memorial Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Cumberland</i>  |  | 9c. COUNTY OF DEATH<br><i>Allegany</i>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Allegany</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Corriganville</i>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>Box 347</i>   |  |  |  | 10f. ZIP CODE<br><i>21524</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Employee</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Flushing Shirt Factory</i>                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Troy Collins</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Shirley (King)</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>James Gordon</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>18 Centennial Street, Frostburg, MD 21532</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Biertown Cemetery 04/09</i>  |  | 20c. LOCATION — City or Town, State<br><i>Rawlings, MD</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James J. Scarpelli</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Scarpelli Funeral Home<br/>Cumberland, MD 21502</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | e. <i>Acute asthmatic exacerbation</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Chronic intrinsic asthma</i>  |  |   |  | Approximate Interval Between Onset and Death<br><i>1 1/2 hrs</i>                                    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <i>14 yrs</i>   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> Dpty med ex  |  |  |  | 29c. LICENSE NUMBER<br><i>D09157</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>April 6, 1996</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Paul Snow, M.D. 124 w 3rd st Cumb Md 21502</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 9 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12295

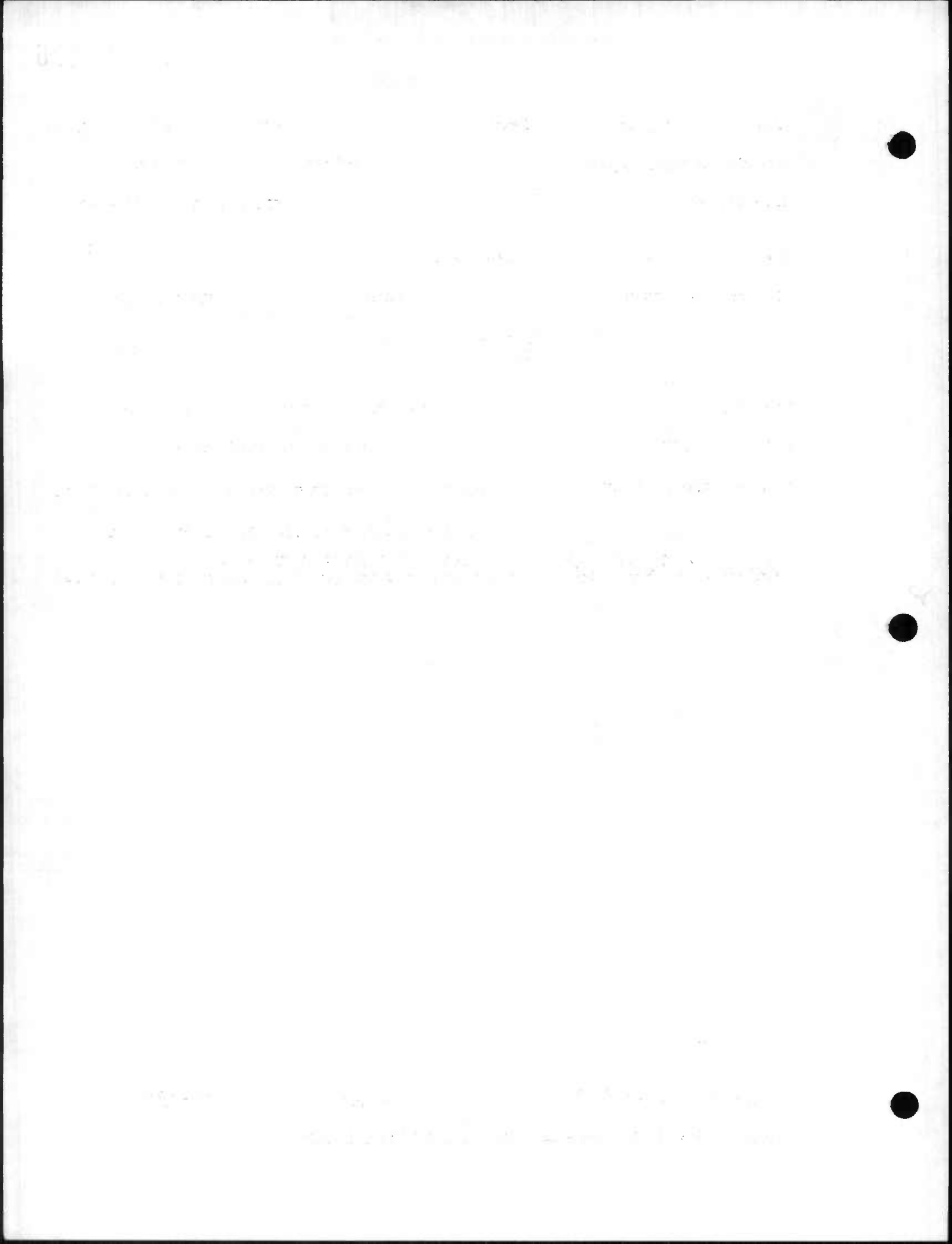
## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |
|---|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John Raymond Greer  |  |   |   | 2. Date of Death<br>Month Day Year<br>April 14 1996  |  | 3. Time of Death<br>2:50 A:M   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>LaPlata  |  | 4c. County of Death<br>Charles   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-16-7393  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F             | 7. Age (In yrs. last birthday)<br>77 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>FEB. 28, 1919   |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MARYLAND  | 10b. County<br>CHARLES   | 10c. City, Town or Location<br>INDIAN HEAD  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>#104 WOODLAND ROAD  |  |   |   | 10f. Zip Code<br>20640   |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941 - 1945   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9TH GRADE<br>College (14 or 5+) College (14 or 5+)   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HEAVY EQUIPMENT OPERATOR   |   |  | 18b. Kind of Business/Industry<br>GOVERNMENT   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>GEORGE N. GREER  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>RACHEL ANN ROSS GREER   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)<br>DOROTHY MASON/ DAUGHTER   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>#10858 MAPLEWOOD COURT, WALDORF, MARYLAND 20601   |  |  |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SMITH CHAPEL CHURCH CEM.  |   | Date<br>4/20/96  |  | 20c. Location - City or Town, State<br>PISGAH, MARYLAND  |  |
|   | 21. Signature of Funeral Service Licensee<br>Lidia C. Thornton Johnson  |  |   |   | 22. Name and Address of Facility<br>THORNTON FUNERAL HOME, P.A.<br>#3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. PULMONARY EDEMA<br>Due to (or as a consequence of):<br>b. PNEUMONITIS<br>Due to (or as a consequence of):<br>c. Generalized Weakness<br>Due to (or as a consequence of):<br>d. Hypotension |  |   |   |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br>2 days  |  |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Anemia, cerebral ischemia, senility, decubiti ulcers<br>Urinary Tract Infection.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |   |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28d. Describe how injury occurred<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |
|   | 29b. Signature and title of certifier<br>Aurelio C. DelaPaz, MD   |  |   |   | 29c. License number<br>D-16160   |  | 29d. Date signed (Month, Day, Year)<br>04-14-96  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Aurelio DelaPaz MD 128 Route 6 West P.O. Box 1230 LaPlata, Md 20646   |  |   |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>APR 16 1996  |  |   |   | 32. Registrar's Signature<br>Julia Anderson Randall  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 12296

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LENA MAY GESELL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 13, 1996</b>   |  | 3. TIME OF DEATH<br><b>8:48 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-32-9641</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 19, 1936</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>111 West Main Street</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>   |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Carroll</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>111 West Main Street</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21157</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bank Operations</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter LeRoy Gesell</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emily Alverta Leppo</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ethel L. Crowl</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1410 Joleen Lane, Westminster, MD 21158</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Trinity Lutheran Cemetery 4/16</b>   |  | 20c. LOCATION — City or Town, State<br><b>Westminster, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Swax &amp; Lahey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Myers Funeral Home<br/>91 Willis Street, Westminster, MD 21157</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. metastatic cancer of the breast</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 YRS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Salvatore Spasich M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D01079</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/15/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Park W. Expenshade M.D. 419 Malcolm Drive, Westminster, MD 21157</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 16 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12297

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |                                   |  |
|---|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rose C. Green   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 8, 1996   |  |   |  | 3. TIME OF DEATH<br>5:15 A M  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-48-3945  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>91 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Feb. 28, 1905        |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Northampton Manor Nursing Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |   |  | 9c. COUNTY OF DEATH<br>Frederick  |  |                                   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |   |  |                                   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Carroll  |  | 10c. CITY, TOWN OR LOCATION<br>Mount Airy   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |                                   |  |
| 10e. STREET AND NUMBER<br>6006 Ridge Road   |  |   |  | 10f. ZIP CODE<br>21771  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                     |  |   |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Public Schools            |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Alvin Francis Conaway  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bessie Leatherwood   |  |   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jane C. Wagner  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1105 North Main Street, Mount Airy, Maryland 21771   |  |   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Pine Grove Cemetery  |  | DATE<br>4/11  |  | 20c. LOCATION — City or Town, State<br>Mount Airy, Maryland |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Olin L. Molesworth   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Olin L. Molesworth, P.A., Funeral Home<br>26401 Ridge Road, Damascus, Maryland 20872  |  |   |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Prob Recurrent CVA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>arteriosclerosis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br>? Moments.<br>Years.  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                                    |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |   |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |   |  | 29c. LICENSE NUMBER<br>D26499   |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 9, 1996        |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ronald E. Miller, M.D., #4 Culwell Drive, Mount Airy, Maryland 21771   |  |   |  |   |  |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 10 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Stevenson Randall  |  |   |  |   |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12298

## Certificate of Death

Reg. No.

Amended # 26. P.G.C. 412-96 CR

|   |   |  |  |  |  |   |  |   |  |  |
|---|---|--|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ann Graham</b>                        |  |  |  |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>3</b> Year <b>1996</b> |   | 3. Time of Death<br><b>9:47 PM</b>                                 |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>12600 Blackwell Lane</b> |  |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Bowie</b>                 |   | 4c. County of Death<br><b>Prince George's</b>                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220 58 9299</b>   |  | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 30, 1950</b>          |   | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b> |  |
|   | Usual Residence of Decedent   |  |  |  |  |   |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   |  | 10b. County<br><b>Prince George's</b>  |  |  | 10c. City, Town or Location<br><b>Bowie</b>   |  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                       |  |
| 10e. Street and Number<br><b>2800 Botany Lane</b>   |   |  |  |  | 10f. Zip Code<br><b>20715</b>                    |   |  | 10g. Citizen of What Country?<br><b>United States</b> |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>   |  |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Data Analyst</b>                     |  |  | 16b. Kind of Business/Industry<br><b>NYMA, Inc.</b>   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George F. Talbert</b>   |   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna V. Bradley</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephen Graham</b>   |   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2800 Botany Lane Bowie Maryland 20715</b> |  |   |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery 4/9/96</b>  |  |  | 20c. Location - City or Town, State<br><b>Bowie Maryland</b>  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Robert E. Evans</b>   |   |  |  |  |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>                         |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cleoblastoma Multiforme (Brain tumor)</b>   |   |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 yr.</b>                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |   |  |  |  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   |  | 28. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |   |  |   |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br><b>1 Yes 2 No</b>                            |   | 28d. Describe how injury occurred                                  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  | 29b. Signature and title of certifier<br><b>David Weisher MD</b>   |  |  | 29c. License number<br><b>D 33508</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>4/4/96</b>               |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7525 Greenway Cir Dr. T-8 Greenbelt Md. 20770</b>  |   |  |  |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>   |   |  | 32. Registrar's Signature<br><b>John H. Harker</b>   |  |  |   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State  
Registrar

2000-000000

0000 00 0000

96 12299

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Harry F. Haas   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1996  |  | 3. TIME OF DEATH<br>7:15 A. M   |   |
| 4. SOCIAL SECURITY NUMBER<br>091-34-2225  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>54 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec 29, 1941   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>117 Kirkcaldy Dr.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  | 9c. COUNTY OF DEATH<br>Cecil  |   |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Cecil   |  | 10c. CITY, TOWN OR LOCATION<br>Elkton   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>117 Kirkcaldy Dr.   |  |  |  | 10f. ZIP CODE<br>21921  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Oct 1963- Aug 1966 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE - American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>2  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Owner/ Dry Cleaning Firm                                 |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Self Employed/ Dry Cleaning   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank Haas   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Christina Mueller  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lorraine Haas   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>117 Kirkcaldy Dr., Elkton, MD 21921  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>All Saints Cemetery   |  | DATE<br>4/17/96   |  | 20c. LOCATION - City or Town, State<br>Wilmington, DE   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert T. Jones & Foard, Inc.<br>122 W. Main St., Newark, Del. 19711  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Small Cell Lung Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>9 mo  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D15314   |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 15, 1996   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>H. Farkas, MD Northern Chesapeake Hospice, Elkton, MD 21921  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 16 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12300

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Hoffman

2. Date of Death

Month Day Year  
April 7, 1996

3. Time of Death

5:11 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-32-5235

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Oct. 18, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

328 Madison Street, Apt. A

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

18b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Hubert

HOFFMAN

18. Mother's Name (First, Middle, Maiden Surname)

Ethel

OREM

19a. Informant's Name/Relationship (Type, Print)

Mrs. Patsy Ann Hoffman, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

328 Madison Street, Apt. A, Frederick, Md. 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, April 10, 1996

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Graf MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church Street, Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Coronary artery disease*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Graf

29c. License number

21648

29d. Date signed (Month, Day, Year)

4/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kusay BARAKAT 310 W 9th Street Frederick MD 21701

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

John Stuckler-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

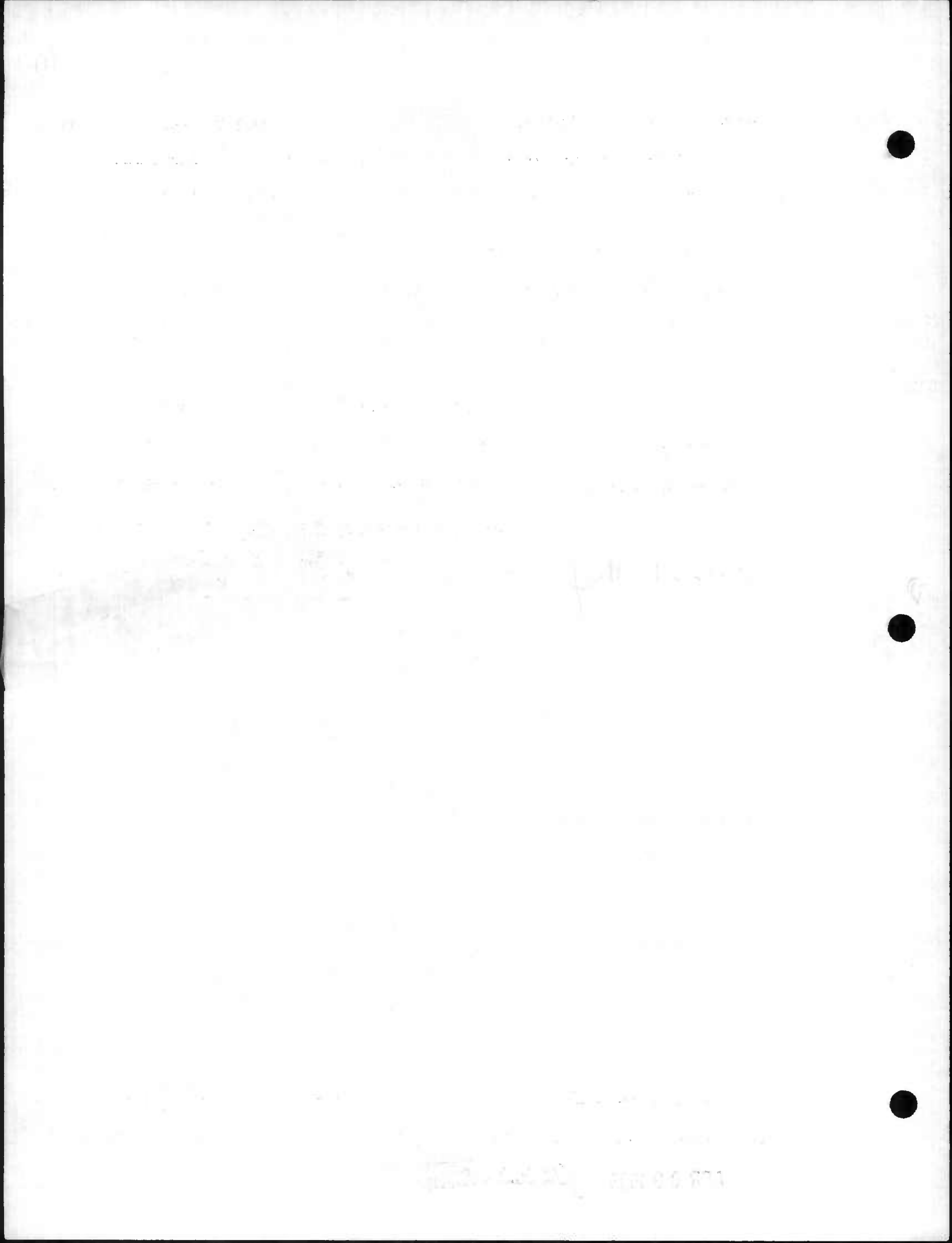
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



APR 02 1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12301

## Certificate of Death

Reg. No.

|                                     |   |  |   |  |   |  |  |  |  |  |
|-------------------------------------|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Walton Howell</b>  |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 11 1996</b>   |  | 3. Time of Death<br><b>1030 AM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Mary Ann Allen Care home</b>   |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Warwick Md.</b>   |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>717-07-5338</b>   |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |
|                                     | 6. Date of Birth (Month, Day, Year)<br><b>Mar. 12, 1907</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Iron Hill, MD</b>  |  | 10a. State<br><b>DE</b>   |  | 10b. County<br><b>New Castle</b>   |  | 10c. City, Town or Location<br><b>Newark</b>   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1463 Otts Chapel Rd.</b>   |  | 10f. Zip Code<br><b>19711</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
|                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |
|                                     | 16b. Kind of Business/Industry<br><b>Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Edward Ott Walton</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Bradly</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Harry E. Howell/ Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1463 Otts Chapel Rd., Newark, DE 19711</b>                                 |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Otts Chapel Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/13/96 Newark, DE</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Robert T. Jones &amp; Foard, Inc.<br/>122 W. Main St., Newark, DE 19711</b>   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Alzheimer's disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Parkinsonism</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
|                                     | 29b. Signature and title of certifier<br><b>Wallace Obenshain M.D.</b>  |  | 29c. License number<br><b>D 07129</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 12, 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wallace Obenshain, M.D. Cecilton, Md. 21913</b>   |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>   |  | 32. Registrar's Signature<br><b>Jahia Davidson-Randall</b>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





96 12302

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eva May Hooper  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 13, 1996  |  |  |  | 3. TIME OF DEATH<br>6:00 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-26-3497  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>87 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Mar 9, 1909                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>William Hill Health Care Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cambridge  |  |  |  | 9c. COUNTY OF DEATH<br>Dorchester   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Dorchester  |  | 10c. CITY, TOWN OR LOCATION<br>Cambridge  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>3 Belvedere Avenue  |  |  |  | 10f. ZIP CODE<br>21613  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>US  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Dietary Technician   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>State Hospital  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Fred Towers  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace Marvel   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Faye H. Wroten  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Belvedere Avenue Cambridge, Maryland 21613   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>East New Market Cemetery  |  | DATE<br>4/15  |  | 20c. LOCATION — City or Town, State<br>East New Market, Md.                          |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Thomas Funeral Home, P.A.<br>700 Locust St. Cambridge, Maryland 21613   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Concurrent Heart Failure</u><br>b. <u>Hypertension</u><br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>5 yrs<br>10 yrs   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Asymptomatic, symptomatic Chronic Hypertension</u>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D26388   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/16/96                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael Fackler MD 302 Collins, Harlock MD 21643   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 16 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12303

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |                          |                                |  |   |   |  |  |
|---|---|--|---|---|---|--------------------------|--------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Teresa Jean HIGGINS   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 12, 1996  |                          |                                |  | 3. Time of Death<br>12:40 p.  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>14343-A Stottlemeyer Road   |  |   |   | 4b. City, Town, or Location of Death<br>Smithsburg  |                          |                                |  | 4c. County of Death<br>Washington   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-64-1814  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>41 Yrs.   |                          | If Under 1 Year<br>Months Days |  | 8. Date of Birth (Month, Day, Year)<br>May 16 1954                                      |   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |   |   |   |                          |                                |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Smithsburg   |                          |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |
|   | 10e. Street and Number<br>14343-A Stottlemeyer Road   |  |   |   | 10f. Zip Code<br>21783  |                          |                                |  | 10g. Citizen of What Country?<br>U.S.A.   |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                        |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>clerk/typist   |                          |                                |  | 16b. Kind of Business/Industry<br>book publication                                      |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Robert Lee Willard   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bonnie Harne   |                          |                                |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Dale A. Higgins/husband   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14343-A Stottlemeyer Road, Smithsburg, Maryland 21783  |                          |                                |  |   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Lawn Memorial Gardens 4-15-96 Hagerstown, Md.                         |   | 20c. Location - City or Town, State   |                          |                                |  |   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>▶  |  |   |   | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |                          |                                |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Bronchopneumonia Due to (or as a consequence of): 4 d<br>b. Prob hypercalcemia Due to (or as a consequence of): 7 d<br>c. Bone metastases Due to (or as a consequence of): 8 y -<br>d. Breast carcinoma 10 y -<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |                          |                                |  |   |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |                          |                                |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |   |                          |                                |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                          |                                |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                          |                                |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |   |                          |                                |  |   |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |   |  |   | 29c. License number<br>014625   |   |                          |                                | 29d. Date signed (Month, Day, Year)<br>Apr 13, 1996                                  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>501 W. 7th Street Frederick Md 21701 DR. RAUCH  |   |  |   |   |   |                          |                                |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1996  |   |  |   | 32. Registrar's Signature<br>[Signature]  |   |                          |                                |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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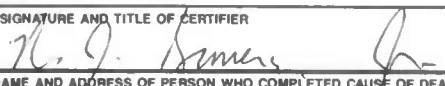

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NELLIE C. HOOK</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 4, 1996</b>   |  | 3. TIME OF DEATH<br><b>10:20 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-22-3118</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 23, 1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |  |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Allegany</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>220 Sommerville Avenue</b>  |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary (0-12)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Assistant Personnel Director</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail Store</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer C. Powers</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara E. (Eline)</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol Clark</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2702 George Washington Hwy., Oakland, MD. 21550</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>4/9/96 Mt. Savage Methodist Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Mt. Savage, MD.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>309-311 Decatur St., Cumberland, MD. 21502</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC INTERSTITIAL LUNG DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>10 years</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ISCHEMIC CARDIOMYOPATHY</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 14865</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 5, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 9 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12305

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>STARR <i>Moats</i> HARTMAN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 7, 1996  |  | 3. TIME OF DEATH<br>5:25 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-36-4373   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 10, 1928  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Memorial Hospital & Medical Center   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland  |  |
| 9c. COUNTY OF DEATH<br>Allegany  |  |   |  | 10a. STATE<br>Maryland   |  |  |  |
| 10b. COUNTY<br>Allegany  |  | 10c. CITY, TOWN OR LOCATION<br>Westernport  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>24432 Pine Hill Road   |  |
| 10f. ZIP CODE<br>21562   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                          |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Elza Moats   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Beatrice Hardesty   |  | 19a. INFORMANT'S NAME (Type/Print)<br>Jonathan Michael   |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6601 Overlook Ct. Eldersburg, Md. 21784   |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sunset Memorial Park 4-9-96   |  | 20c. LOCATION — City or Town, State<br>Cumberland, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Ernest A. Riley, Jr.  |  | 22. NAME AND ADDRESS OF FACILITY<br>230 Baltimore Ave. Cumberland<br>Leisure-Stein, Inc. Md. 21502  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Urinary Tract Infection<br>Metastatic Liver Disease<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br>D33280  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 8, 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Sunil Gupta Johnson Heights Medical Building Cumberland, MD. 21502  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 09 1996   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

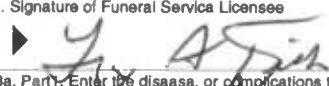
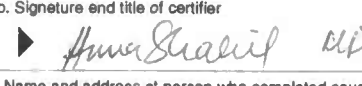
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LILLIAN RUSSELL HUME</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 9 1996</b>  |   | 3. Time of Death<br><b>10:35 A.M.</b>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |   | 4c. County of Death<br><b>ALLEGANY</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>233-40-9995</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1908</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>W. Va.</b>  |   | 10b. County<br><b>Morgan</b>  |  | 10c. City, Town or Location<br><b>Paw Paw</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>Winchester Street</b>   |   |   |  | 10f. Zip Code<br><b>25434</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |   | 16b. Kind of Business/Industry<br><b>Education</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Lemuel H. Hume</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Edwards</b>   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth M. Hume</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5311 Bangert Ave. White Marsh, Md. 21162</b>   |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Camp Hill Cemetery</b>   |  | Date<br><b>4-12-96</b>   |   | 20c. Location - City or Town, State<br><b>Paw Paw, W. Va.</b>                                  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Miller Funeral Home</b><br><b>P.O. Drawer 1000 Romney, W. Va. 26757</b>   |   |  |   |  |
|  | 23a. Part I. Enter two diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Renal failure</b><br>Due to (or as a consequence of):<br><br>c. <b>Fracture hip and femur</b><br>Due to (or as a consequence of):<br><br>d. <b>Metabolic encephalopathy</b><br><br>Approximate Interval Between Onset and Death<br><br>12 days<br><br>unknown<br><br>14 days<br><br>12 days |   |   |  |  |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Decubitus ulcer, diabetes</b>   |   |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Ending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>MARCH 28, 1996</b>   |   | 28b. Time of Injury<br><b>A M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>PATIENT FELL AT HOME!</b> |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE!</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>P.O. BOX 44 WINCH RD. PAW PAW</b>  |   |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><br><b>HUMA SHAKIL M.D.</b>   |   | 29c. License number<br><b>D 46346</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 10 1996</b>                                 |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HUMA SHAKIL M.D. JOHNSON HEIGHTS MEDICAL BLDG. CUMBERLAND, MD 21502</b>   |  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12307

## Certificate of Death

Reg. No.

|   |  |   |   |                                 |  |  |  |  |  |  |
|---|--|---|---|---------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY B. HOWE</b>   |   |   |                                 |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>16</b> Year <b>1996</b>        |  | 3. Time of Death<br><b>2230</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |   |   |                                 |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>                    |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>186-24-7508</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                 | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>10-20-12</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>Greencastle, Pa.</b>                            |  |
|   | Usual Residence of Decedent<br><b>October</b>  |   |   |                                 |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Washington</b>  |                                 | 10c. City, Town or Location<br><b>Smithsburg</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>22 Blue Mountain Estate</b>   |   |   |                                 | 10f. Zip Code<br><b>21783</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ira Fetherhoff</b>   |   |   |                                 |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jane Yeckle</b> |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty L Frazee</b>  |   |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>G.D. Mont Alto Pa 17237</b>  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Macedonia Cemetery</b>   |                                 | Date<br><b>4/20</b>  |  | 20c. Location - City or Town, State<br><b>Franklin Co Pa.</b>                |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>James A Bower</b>  |   |   |                                 | 22. Name and Address of Facility<br><b>Grove Funeral Home, Inc 505 Broad St Waynesboro, Pa 17268</b>   |  |  |  |  |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Leukemia</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                 |  |  |  |  |  |  |
|   | 23f. Approximate Interval Between Onset and Death<br><b>3 weeks</b>  |   |   |                                 |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |                                 |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |   |                                 |  |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |   |                                 |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |                                 |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>W B Kerns MD</b>  |  |   |   |                                 |  | 29c. License number<br><b>D38451</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/18/96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>W B Kerns 22911 Jefferson Blvd Smithsburg MD</b>   |  |   |   |                                 |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 18 1996</b>   |  | 32. Registrar's Signature<br><b>Johi Anderson-Kardell</b>   |   |                                 |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
political situation and  
the state of the  
army.



THE SECRETARY OF THE INTERIOR

WASHINGTON, D. C.

DECEMBER 1, 1954

TO THE SECRETARY OF THE INTERIOR

FROM THE SECRETARY OF THE INTERIOR

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12309

## Certificate of Death

Reg. No.

|   |   |   |   |   |   |  |  |   |
|---|---|---|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Pauline Lewis HOVIS</b>                              |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>14</b> Year <b>1996</b> |  | 3. Time of Death<br><b>10:25 AM</b>  |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Washington County Hospital</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>             |  | 4c. County of Death<br><b>Washington</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-09-9933A</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                          | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 20, 1910</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |
|   | Usual Residence of Decedent   |   |   |   |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Hagerstown</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>320 S. Cleveland Avenue</b>  |   |   |   | 10f. Zip Code<br><b>21740</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> Collage (1-4or 5+) <b>unknown</b>   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>chef</b>  |   |  | 16b. Kind of Business/Industry<br><b>restaurant</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>John William Fouke</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Virginia Negley</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald F. Hovis</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19806 Scott Hill Dr., Hagerstown, Md. 21740</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b> |   | Data<br><b>4-18-96</b>  |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>                             |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Myocardial Infarction with Cardiogenic Shock</b><br>Due to (or as a consequence of):<br><br>b. <b>Following Fracture of the right hip</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br><br><b>24 hrs.</b><br><br><b>4 days</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida  |   | 28a. Date of Injury (Month, Day, Year)<br><b>April 10, 1996</b>   |   | 28b. Time of Injury<br><b>2:00P M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>During nursing care</b>                         |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Nursing Home</b>   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Ravenwood Nursing Home Luther Dr</b>   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>Do1062</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 15, 1996</b>                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edward W. Ditto, III, MD 217 W. Washington St. Hagerstown, Md 21740</b>  |   |   |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 18 1996</b>   |   |   |   | 32. Registrar's Signature<br>  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.



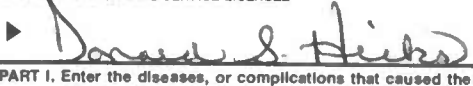




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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARNOLD HUNT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>6</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>4:35P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-42-3879</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 28, 1933</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MARYLAND HEALTH CARE SYSTEM</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Perry Point</b>   |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Cecil</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Elkton</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>24 Oak Road</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21921</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1956 - 1958</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) _____  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Roofing &amp; Siding Installer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alex Hunt</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Justice</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Therman Hunt</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1056 Warburton Road - Elkton, MD 21921</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DE Veterans Memorial Cem. 4/6/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Bear, Delaware</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, MD 21921-5521</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Carcinoma soft palate</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Metastasis to liver</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. _____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. _____</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) _____ |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>ME0063318</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/6/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>OMAR J. PEREZ, M.D. VAMDHCS, Perry Point, MD 21902</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 10 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |   |  |   |  |
|---|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ethel B. Hackney  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Apr. 11, 1996   |  |  |  | 3. TIME OF DEATH<br>9:10 PM   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>233-30-0025  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>96 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 22, 1899  |  | 8. BIRTHPLACE (State or Foreign Country)<br>St. Mary's, WV                             |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Medpointe   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  |  |  | 9c. COUNTY OF DEATH<br>Cecil  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Cecil   |   | 10c. CITY, TOWN OR LOCATION<br>Rising Sun   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>P.O. Box 190, 26 N. Walnut St.  |  |  |   | 10f. ZIP CODE<br>21911  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Public & Private School   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Mont L. Bonar  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rachel Jane Delong   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Samuel B. Hackney   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 190, 26 N. Walnut St., Rising Sun, MD 21911   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Odd Fellows Cemetery 4/16/1996  |   | 20c. LOCATION — City or Town, State<br>St. Mary's, WV   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert A. Foard</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>P.O. Box 248, 111 S. Queen St., Rising Sun,<br>R.T. Foard Funeral Home MD 21911   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular Accident</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  |  |  | Approximate interval between Onset and Death<br>4 MONTHS  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Arterial insufficiency right lower extremity.</u>  |  |  |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |   |   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Monte Makows, MD</i>  |  |  |   | 29c. LICENSE NUMBER<br>D-44783  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 12, 1996   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MONTE MAKOWS 111 WEST HIGH STREET, ELKTON, MD 21921  |  |  |   |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 12 1996  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12313

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |                                |  |  |                                   |  |
|---|--|--|---|---|--|--------------------------------|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Virginia Elizabeth House   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 4, 1996  |                                | 3. Time of Death<br>9:05 A.M.  |  |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Frederick  |                                | 4c. County of Death<br>Frederick   |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-48-5865   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>July 6, 1913  | 9. Birthplace (State or Foreign Country)<br>Maryland |                                   |  |
|   | Usual Residence of Decedent  |  |   |   |  |                                |  |  |                                   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |   | 10c. City, Town or Location<br>Frederick   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                   |  |
|   | 10e. Street and Number<br>209 South Market Street  |  |   |   | 10f. Zip Code<br>21701   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |                                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |  |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4or 5+) 11   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   | 16b. Kind of Business/Industry<br>Own Home   |                                |  |  |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Ebert  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma V. Bartgis   |                                |  |  |                                   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Gilmore Wayne House  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8429 Fingerboard Road, Frederick, Md. 21704   |                                |  |  |                                   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery   |   | Date<br>April 9, 1996  |                                | 20c. Location - City or Town, State<br>Frederick, Maryland                                       |  |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br>Richard C. C. Basford 00021   |  |   |   | 22. Name and Address of Facility<br>Keeney and Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701  |                                |  |  |                                   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial infarction<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                |  |  |                                   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus<br>Melanoma (C) leg  |  |   |   |  |                                |  |  |                                   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |                                   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  | 28d. Describe how injury occurred |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Austin Pearre  |   | 29c. License number<br>D09689  |                                | 29d. Date signed (Month, Day, Year)<br>4/4/96  |  |                                   |  |
|   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br>A. Austin Pearre, Jr., M.D. 300 West Ninth Street, Frederick, Maryland 21701   |  |   |   |  |                                |  |  |                                   |  |
|   | 31. Date filed (Month, Day, Year)<br>APR 08 1996   |  | 32. Registrar's Signature<br>John A. ...  |   |  |                                |  |  |                                   |  |





96 12314

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA RUTH HOFFMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>2</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>11:45 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-1011</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 1, 1931</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>10 West 7th Street</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>10 West 7th Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21701</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Mathias Grove</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel Ernestine Morningstar</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn Bowers</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6041 Broken Arrow Drive, New Port, Richey, FL 34653</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                                   |  | DATE <b>4/4</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 NORTH MARKET ST., FREDERICK, MD 21701</b>   |  |   |  |
| 23. PART I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>76 months</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-18191</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-3-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arthur G. Manalo, MD 187 Thomas Johnson Drive, Frederick, Maryland 21701</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 03 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12315

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|---|---|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MOSES WESLEY HATTON, III                             |  |  |  | 2. Date of Death<br>Month Day Year<br>APRIL 1, 1996 |   | 3. Time of Death<br>4:18PM                                       |  |  |   |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL |  |  |  | 4b. City, Town, or Location of Death<br>ROCKVILLE   |   | 4c. County of Death<br>MONTGOMERY                                |  |  |   |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>227-44-0237   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>59 Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br>Jan. 14, 1937             |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C. |   |  |  |  |  |  |
|  | Usual Residence of Decedent  |  |  |  |   |   |  |  |  |   |  |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Frederick   |  | 10c. City, Town or Location<br>Frederick   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |  |  |  |
| 10e. Street and Number<br>8013 Broken Reed Court   |  |  |  | 10f. Zip Code<br>21701   |   | 10g. Citizen of What Country?<br>United States              |  |  |  |   |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1950's |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |   |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Custodian   |   |   | 16b. Kind of Business/Industry<br>Board Of Education             |  |  |   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Moses Wesley Hatton, II   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hilda Batchelor Hatton  |   |   |  |  |  |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Cledythe I. Hatton, wife   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8013 Broken Reed Court Frederick, MD 21701  |   |   |  |  |  |   |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory   |  | Date<br>4/5/96   |   | 20c. Location - City or Town, State<br>Hagerstown, Maryland |  |  |  |   |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702  |   |   |  |  |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>years   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)                       |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |   |   |  |  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 2, 1996 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. LARON LARKE, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |  |  |   |   |  |  |  | 31. Date filed (Month, Day, Year)<br>APR 04 1996  |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12316

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |   |  |   |
|--|--|---|---|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Mollie Alice Hirt  |   |   |   | 2. Date of Death<br>Month Day Year<br>March 30, 1996   |   | 3. Time of Death<br>4:12AM   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Friederick Memorial Hospital   |   |   |   | 4b. City, Town, or Location of Death<br>Friederick   |   | 4c. County of Death<br>Friederick  |   |
| Funeral<br>Director  | 5. Social Security Number<br>234-24-8016   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>48 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>8/29/47  | 9. Birthplace (State or Foreign Country)<br>Kentucky  |
|  | Usual Residence of Decedent  |   |   |   |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>MD   | 10b. County<br>Friederick                                 |   | 10c. City, Town or Location<br>Friederick   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br>5911 Quinn Orchard Road  |   |   |   | 10f. Zip Code<br>21701   |   | 10g. Citizen of What Country?<br>USA   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Procurement Agent   |  | 16b. Kind of Business/Industry<br>Ft. Detrick   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>Homen Bolen   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Stella Mae Patton   |   |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>David E. Hirt  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5911 Quinn Orchard Road, Friederick, MD   |   |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Union Cemetery  |   | Date<br>4/3/96   | 20c. Location - City or Town, State<br>Lovettsville, VA   |  |   |
|  | 21. Signature of Funeral Service Licensee<br>Barbara A. Williams, Owner  |   | 22. Name and Address of Facility<br>John T. Williams Funeral Home<br>100 Petersville Rd Brunswick, MD 21716   |   |  |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. MASSIVE PULMONARY THROMBOEMBOLISM<br>Due to (or as a consequence of):<br>b. CHRONIC HYPERCOAGULABLE STATE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |   |   |  |   |  | Approximate Interval Between Onset and Death<br>IMMEDIATE<br>4 YRS  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                    |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br>Neil Warawick MD |   |   |  |   |  |   |
| 29c. License number<br>D47611  |  | 29d. Date signed (Month, Day, Year)<br>3/30/96            |   |   |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>NEIL WARAWICK MD, 1475 TANEY AVE, #204, FRIEDERICK MD 21702  |  |   |   |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 02 1996   |  |   |   | 32. Registrar's Signature<br>John Davidson  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



96 12317

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GRACE JONES HALL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>29</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>3:45 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-07-9894</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>98</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 24, 1897</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Record Street Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Record Street Home<br/>115 Record Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Executive Secretary</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Stanley Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie Grigg</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Aubrey Dixon</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 Mercer Court Apt. #25-6 Frederick, MD 21701</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | DATE<br><b>3/29</b>   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 NORTH MARKET ST. FREDERICK, MD 21701</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. arteriosclerotic vascular disease</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>b. Congestive heart failure</b>  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebral vascular accident, Hypertension</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Leroy T. Davis</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>001902</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Leroy T. Davis, MD 801 Toll House Avenue, Frederick, Maryland 21701</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12318

## Certificate of Death

Reg. No.

|   |   |                                 |   |   |   |   |  |  |   |  |  |
|---|---|---------------------------------|---|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CARL EZRA HOLTZ</b>                                    |                                 |   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>March 27, 1996</b>  |  | 3. Time of Death<br><b>6: 15 P.M</b>                        |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Health Care Center</b> |                                 |   |   |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>     |  | 4c. County of Death<br><b>Frederick</b>                     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-16-0303</b>   |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>April 24, 1906</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|   | Usual Residence of Decedent   |                                 |   |   |   |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Frederick</b> |   | 10c. City, Town or Location<br><b>Frederick</b>   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>8542 Rocky Springs Rd.</b>   |   |                                 |   | 10f. Zip Code<br><b>21701</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-</b>  |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Court Reporter</b>  |   |   | 16b. Kind of Business/Industry<br><b>County Government</b>   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>GRANVILLE C. HOLTZ</b>  |   |                                 |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADDIE C. WACHTER</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KATHLEEN E. RITTER (daughter)</b>  |   |                                 |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5613 Butterfly Lane / Frederick, Maryland 21703</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Faith United Church of Christ</b>  |   | 20c. Date<br><b>3/30-96</b>   |  | 20d. Location - City or Town, State<br><b>Frederick, Maryland</b>                              |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                                 |   |   |   | 22. Name and Address of Facility<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike/ Frederick, Maryland 21702</b>                                   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>BRAIN Cancer, Probable Astrocytoma</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):                |   |                                 |   |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>3 months</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                 |   |   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |                                 |   |   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |                                 |   |   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                                 |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |  |
|   |   |                                 |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                 |   | 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D21944</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES S. GRISSON<br/>300 W 9th Street<br/>1475 Tancy Ave/ Frederick, Maryland 21702</b>  |   |                                 |   |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 01 1996</b>   |   |                                 |   | 32. Registrar's Signature<br>  |   |   |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12319

## Certificate of Death

Reg. No.

|  |   |                           |   |   |  |  |  |  |
|--|---|---------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Ruth Elaine Henderson   |                           |   |   | 2. Date of Death<br>Month: March Day: 26 Year: 1996  |  | 3. Time of Death<br>3:25 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Friederick Memorial Hospital  |                           |   |   | 4b. City, Town, or Location of Death<br>Friederick   |  | 4c. County of Death<br>Friederick  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-26-1507  |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>77 Yrs. | If Under 1 Year<br>Months: Days:   | If Under 24 Hrs.<br>Hours: Min.  | 6. Date of Birth (Month, Day, Year)<br>2/13/19   | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent   |                           |   |   |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD  | 10b. County<br>Friederick | 10c. City, Town or Location<br>Knoxville  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>P.O. Box 107  |                           |   | 10f. Zip Code<br>21758                    |  | 10g. Citizen of What Country?<br>USA   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: x   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10  |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   | 16b. Kind of Business/Industry<br>Housewife  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles Marshall Smallwood   |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lillie Mae Weedon Smallwood   |  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>Richard P. Henderson  |                           |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 107 Knoxville MD 21758   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bethel AME Church Cemetery  |   | Date<br>Bunkittsville MD   |  | 20c. Location - City or Town, State  |  |
|  | 21. Signature of Funeral Service Licensee<br>Barbara A. Williams, Owner   |                           | 22. Name and Address of Facility<br>John T. Williams Funeral Home<br>100 Petersville Rd Brunswick MD 21716  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC ADENOCARCINOMA OF THE RECTUM<br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                           |   |   |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                           |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |                           | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |   |                           | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                           | 29b. Signature and title of certifier<br>Bryan O'Connor, MD   |   | 29c. License number<br>D31761  |  | 29d. Date signed (Month, Day, Year)<br>3/26/96   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST., FREDERICK, MD 21701   |                           |   |   |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>APR 02 1996  |                           | 32. Registrar's Signature<br>Bryan O'Connor   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




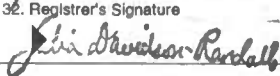
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12320

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
|---|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Margaret F. Harpalas  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 26 1996   |  |   |  | 3. Time of Death<br>2:10 P.M.  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Frederick   |  |   |  | 4c. County of Death<br>Frederick   |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-18-0109  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br>Oct. 26, 1913  |  | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Walkersville   |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |
|   | 10e. Street and Number<br>210 Albany Avenue West  |  |   |  | 10f. Zip Code<br>21793  |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Nurse's Aide/Waitress   |  |   |  | 16b. Kind of Business/Industry<br>None   |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Raymond Hamilton   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie LaRue Flautt                        |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Beck   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>210 Albany Avenue West, Walkersville, MD 21793   |  |   |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Crematory  |  | Date<br>3/28  |  | 20c. Location - City or Town, State<br>Smithsburg, Maryland                                     |  |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>1201 NORTH MARKET ST. FREDERICK, MD 21701   |  |   |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat stroke. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute upper GI Hemorrhage<br>Due to (or as a consequence of):<br>b. Pancreatitis<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>e. Atrial Fibrillation |  |   |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>24 hrs<br>48 hrs |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atrial Fibrillation   |  |   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| State<br>Registrar  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury<br>(Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |  |  |  |  |
|   | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |  |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>William H. Convey, MD  |  |   |  | 29c. License number<br>D2305  |  |   |  | 29d. Date signed (Month, Day, Year)<br>3/27/96   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>WILLIAM H. CONVEY, M.D. 195 THOMAS JOHANSON DR, FREDERICK, MD |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 28 1996  |   |  |   | 32. Registrar's Signature<br> |   |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 12321

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Barbara Lorraine HILTNER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 25, 1996</b>   |  | 3. TIME OF DEATH<br><b>12:20 P. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-20-3118</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 20, 1926</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4713 Tuscarora Road</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Point of Rocks</b>  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Point of Rocks</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4713 Tuscarora Road</b>  |  |   |  | 10f. ZIP CODE<br><b>21777</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Banker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Vice President - Banking</b>                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ralph David Fout</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith Purdy</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Stuart Cramer</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>284 Maplewood Place, Walkersville, Md. 21793</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery March 30, 1996 Frederick, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leland C.C. Bassford MD0021</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md. 21701</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC ADENOCARCINOMA OF BREAST</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death <b>9 YEARS</b> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Brian M. O'Connor</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D31761</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 29, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Brian M. O'Connor, M.D., 501 West Seventh Street, Frederick, Maryland 21701</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 29 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Corrected Line 1 JP,  
FCHD

96 12322

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Gilma Gilda Lewis HAMM</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 25, 1996</i>   |  | 3. TIME OF DEATH<br><i>9:30 P. M.</i>   |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>237-30-7996</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>70</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Oct. 21, 1925</i>                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>North Carolina</i>                                     |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Sunrise Retirement Home</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Frederick</i>   |  |   | 9c. COUNTY OF DEATH<br><i>Frederick</i> |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |   |  |  |  |
| 10a. STATE<br><i>Florida</i>  |  | 10b. COUNTY<br><i>Putnam</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>East Palatka</i>  |  |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><i>Rt. 2, Box 172</i>   |  |   |  | 10f. ZIP CODE<br><i>32131</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |   |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>1</i> College (1-4 or 5+) <i>1</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Own Home</i>   |  |   |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>George Grady BRINSON</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Gladys Lewis MORRIS</i>   |  |   |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mr. George W. Hamm</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>P.O. Box 423, Jefferson, MD 21755</i>   |  |   |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory, Mar 26, 1996 Smithsburg, Maryland</i>   |  | 20c. LOCATION — City or Town, State   |  |   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Allan H Ruby M00703</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Keeney &amp; Basford P.A. Funeral Home<br/>106 East Church St., Frederick, MD 21701</i>  |  |   |  |   |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Extensive atherosclerosis of</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>lung with heart</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>metastases</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>4 mo</i> |  |   |  |   |  |   |   | Approximate interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   |   |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Residence</i> |  |   |  |   |   |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. P. Gregory Rausch</i>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><i>D14626</i>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>March 26, 1996</i>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Dr. P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, MD 21701</i>   |  |   |  |   |  |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 28 1996</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |   |   |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12323

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT F. HARRIS III

2. Date of Death

MARCH 25, 1996

3. Time of Death

8:35 PM

4a. Facility Name (If not institution, give street and number)

6317 PENNSYLVANIA AVE

4b. City, Town, or Location of Death

FORRESTVILLE, MD PRINCE GEORGES

4c. County of Death

5. Social Security Number

577 58 3982

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUN 1, 1944 WASH. D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

FORESTVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6317 PENNSYLVANIA AVE

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICE MANAGER

16b. Kind of Business/Industry

SCHOOL

17. Father's Name (First, Middle, Last)

ROBERT F. HARRIS JR.

18. Mother's Name (First, Middle, Maiden Surname)

GWENDOLYN BARBOUR

19a. Informant's Name/Relationship (Type, Print)

CHRISTINA HARRIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1914 COUNTY RD.#104 FORESTVILLE, MD 20747

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL

Date

APR 3, 1996 LANDOVER, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RALPH WILLIAMS FUNERAL SVC  
517 11th STREET S.E.

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATIC FAILURE

Due to (or as a consequence of):

b. HEPATITIS B

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV INFECTION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

6091 D C

29d. Date signed (Month, Day, Year)

APRIL 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM HURWITZ, MD 4830 V STREET N.W. WASHINGTON, D.C. 20007

31. Date filed (Month, Day, Year)

APR 12 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



## State of Maryland / Department of Health and Mental Hygiene

Amended #1. P.G.Co. 4-12-96 CR Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CEPHUS Cephas D.

HUGHES

2. Date of Death

Month Day Year  
APRIL 4, 1996

3. Time of Death

0650 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ROUTE#450 WEST OF HIGH BRIDGE ROAD

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

217-32-9475

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

13401 Katrinka Drive

10f. Zip Code

20720

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Cephas F. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Rosetta Lee

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Hughes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

4/6/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Multiple myeloma  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ROADWAY

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

4-4-96

28b. Time of  
Injury

0500 M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

DRIVER OF AUTO/STUCK  
TREE28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

Rt 450, Bowie Md.

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL 4, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Amber Xon

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

APR 12 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or mark

2201 31 39A

96 12325

1. Decedent's Name (First, Middle, Last)  
Walter Lawrence HICKLE

2. Date of Death  
Month Day Year  
April 8, 1996

3. Time of Death  
1:42 A.M.

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)  
Doctors' Community Hospital

4b. City, Town, or Location of Death  
Lanham

4c. County of Death  
Prince George's

5. Social Security Number  
415 05 8200

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)  
76

8. Date of Birth (Month, Day, Year)  
Feb. 4, 1920

9. Birthplace (State or Foreign Country)  
Tennessee

Funeral Director

10a. State  
Maryland

10b. County  
Prince George's

10c. City, Town or Location  
Mitchellville

10d. Inside City Limits  
☒ Yes ☐ No

10e. Street and Number  
11503 Dundee Drive

10f. Zip Code  
20721

10g. Citizen of What Country?  
United States

11. Marital Status  
☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: 40-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 2 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Lt. Colonel

16b. Kind of Business/Industry  
U.S. Army

17. Father's Name (First, Middle, Last)  
Esco Sterling

18. Mother's Name (First, Middle, Maiden Surname)  
Stella Luttrell

19a. Informant's Name/Relationship (Type, Print)  
Floretta Hickle Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
11503 Dundee Drive Mitchellville Maryland 20721

20a. Method of Disposition  
☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Metropolitan Crematory 4/9/96

20c. Location - City or Town, State  
Alexandria Virginia

21. Signature of Funeral Service Licensee  
Robert E. Evans Pres

22. Name and Address of Facility  
Robert E. Evans Funeral Home, P.A.  
16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
a. CARDIOPULMONARY ARREST  
Due to (or as a consequence of):  
b. CARCINOMA LUNG  
Due to (or as a consequence of):  
c. CONGESTIVE HEART FAILURE  
Due to (or as a consequence of):  
d.

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
C. J. ... MD

29c. License number  
D 25802 MD

29d. Date signed (Month, Day, Year)  
4/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
AMJAD M RASUL MD #104 4700 BERWYN Hs Rd. College Park MD 20740

31. Date filed (Month, Day, Year)  
APR 12 1996

32. Registrar's Signature  
John ...

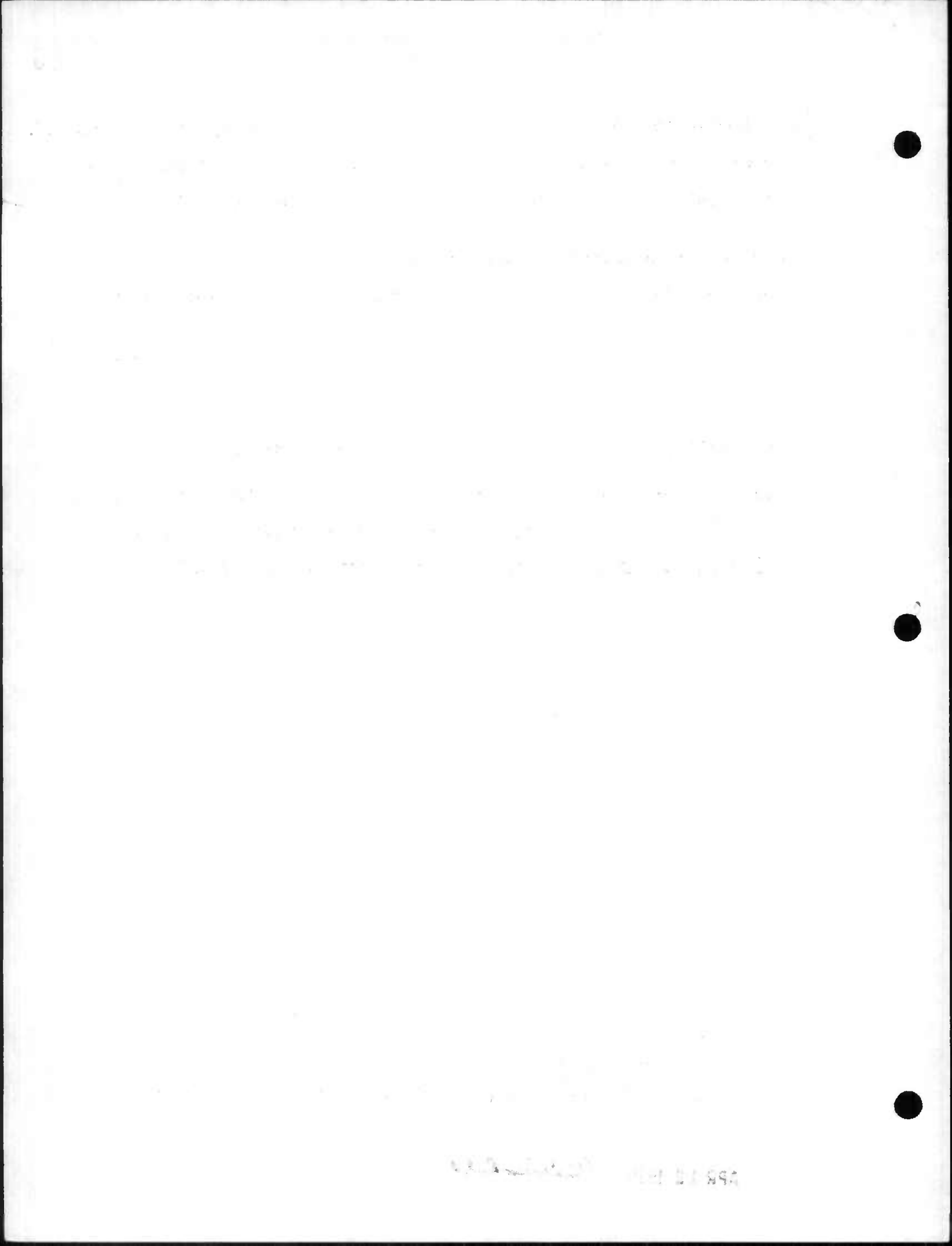
State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96 12326

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Zelia M. Hopkins</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>8</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>1012 A</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-76-3072</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>February 13, 1954</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash., DC</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland University Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Maryland</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>DC</b>  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>704 12th Street S.E. Apt #31</b>  |  |
| 10f. ZIP CODE<br><b>20003</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Data Entry Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Saturn Corporation</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Cabbagestalk</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Stroy</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eliza Williams</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 12th St. S.E., #31, Wash., DC 20003</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>4-12 Landover, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. P. Marshall</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th St. N.W., Wash., DC 20011</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acidemia.</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>Acidemia.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>1hr</b><br>b. <b>Electrical Activity.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>1hr</b><br>c. <b>Pulmonary Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>1hr</b><br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Asthma</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D48071</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 8, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HOANG VI TRAN, M.D. 22 SOUTH GREENE ST, BALTIMORE MD 21201</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 12 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

628

APR 17 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12327

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mao-Lin

Ho

2. Date of Death

April 1, 1996

Year

3. Time of Death

8:13A

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

216-06-2829

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 19, 1921

9. Birthplace (State or Foreign Country)

CHINA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Glenn Dale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7912 Wingate Drive

10f. Zip Code

20769

10g. Citizen of What Country?

China

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Colonel

16b. Kind of Business/Industry

Chinese Military

17. Father's Name (First, Middle, Last)

Wu-Chun Ho

18. Mother's Name (First, Middle, Maiden Surname)

Unknown Kuan

19a. Informant's Name/Relationship (Type, Print)

Daisy Ho Hu-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7912 Wingate Drive, Glenn Dale, MD 20769

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

April 9, 1996 ElkrIDGE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home  
9013 Annapolis Road, Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

b. old myocardial infarct

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d. subdural hematoma

Approximate Interval Between Onset and Death

one hour

Ten years

Fifteen years

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure with Diabetes  
Hypertension  
Hypochloremia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13339

29d. Date signed (Month, Day, Year)

4/1/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

T. CHANCHEN, 8824 Cunningham Drive, Bryn Mawr, Md

State  
Registrar

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(2)



96 12328

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOYCE W. JOHNSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> , DAY <b>14</b> , YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>4:16 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-36-3446</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01/04/41</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>508 Prince Street</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>                                     |  |
| 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Wicomico</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>508 Prince Street</b>  |  |
| 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>nursing</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>medical</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herman Wiechman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mae Stansbury Wiechman</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Johnson, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>508 Prince St., Salisbury, MD. 21801</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory 4/15</b>   |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patricia L. Dennis</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Dennis Funeral Home, P.O. Box 87<br/>Snow Hill, Md. 21863</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Lung METASTASES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. RENAL CELL CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Approximate Interval Between Onset and Death<br><b>6 mo</b><br><b>6 mo</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Craig W. Caldwell</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D33622</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-15-96</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CRAIG W CALDWELL 2 AURORA ST CAMBRIDGE, MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Etha R Johnson</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>APRIL 2 1996</i>   |  | 3. TIME OF DEATH<br><i>5:45 P.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-12-9494</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>89</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Oct 2, 1906</i>                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>WV</i>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>CUMBERLAND NURSING HOME</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CUMBERLAND</i>  |  | 9c. COUNTY OF DEATH<br><i>ALLEGANY</i>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Allegany</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Cumberland</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>235 Paca Street Apt 305</i>   |  |  |  | 10f. ZIP CODE<br><i>21502</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i></i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Own Home</i>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Alexander Monroe Barnes</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Della Frances (Ely)</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Erma J. Kergan</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1440 Cavalcade Drive; Youngstown, OH 44515</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Wesley Chapel</i>  |  | DATE<br><i>04/05</i>  |  | 20c. LOCATION — City or Town, State<br><i>Levels, WV</i>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James F Scarpelli</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Scarpelli Funeral Home<br/>Cumberland, MD 21502</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Congestive heart failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>CAD</i>   |  |   |  | Approximate interval Between Onset and Death<br><i>3 days</i>                            |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | years  |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dehydration<br/>Anemia.</i>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Halmos</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>DO 4981</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>April 4, 1996</i>                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>VEREK Halmos 302 Schley St. Cumberland, Md 21502</i>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 09 1996</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Halmos</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12330

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NELLIE A. JONES</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>28</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>21:20</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-22-3663</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 24, 1917</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Allegany</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>203 W. Industrial Blvd.</b>  |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anthony Clay</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary C. (Potts)</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley J. Morgan</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14211 Lower Sunnyside Rd: Mt. Savage, MD 21545</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park 03/31</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James J. Scarpelli</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. EMPHYSEMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. SUPRAVENTRICULAR TACHYCARDIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Poonai</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 36766</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/29/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VIK POONAI M.D. 955 FREDERICK STREET CUMBERLAND, MD 21502</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 04 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12331

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Gloria Gelhaus Jones</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 12, 1996</b>  |  | 3. Time of Death<br><b>2:50 pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Calvert County Nursing Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |  | 4c. County of Death<br><b>Calvert</b>   |  |
| 5. Social Security Number<br><b>214 38 0920</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>85</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 8, 1910</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Calvert</b>  |  | 10c. City, Town or Location<br><b>Prince Frederick</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>4550 Dares Beach Road</b>   |  | 10f. Zip Code<br><b>20678</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator-tutor</b>                 |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Frederick Gelhaus</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Antoinette Rehn</b>   |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Robert D. Jones/son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 Fey Road, Chestertown, MD 21620</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Paul's Episcopal Cem</b>   |  | 20c. Location - City or Town, State<br><b>4-15-96 Prince Fred., MD</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, Owings, MD 20736</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Dehydration</b><br>Due to (or as a consequence of):<br><b>b. Esophageal Stricture</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>15 years</b>   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>severe Renal</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Piece of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury<br/>M</b><br><b>28c. Injury at Work?<br/>1 Yes 2 No</b>                            |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>P. Callahan, MD</b>  |  | 29c. License number<br><b>041794</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12 April 96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>P. Callahan - Lyon, MD 120 Hospital Drive Prince Frederick, MD 20678</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1996</b>  |  | 32. Registrar's Signature<br>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

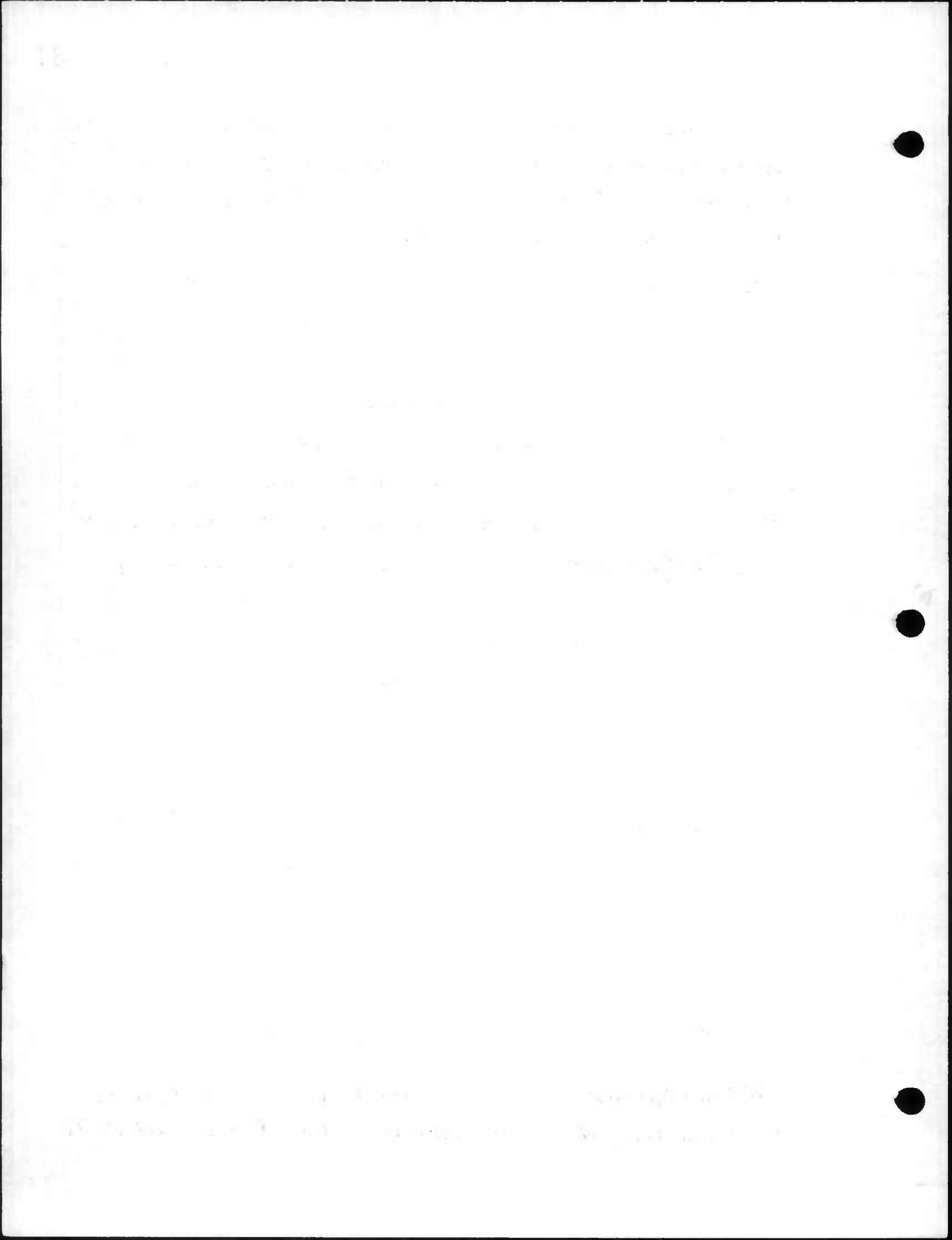
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

24

State  
Registrar



96 12332

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SYLVIA Johnson  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MAR. 20, 1996   |  | 3. TIME OF DEATH<br>11:15 PM   |   |
| 4. SOCIAL SECURITY NUMBER<br>577-86-4081  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAR. 18, 1911                                 |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>-VIRGINIA   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSP.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROCKVILLE                                     |   |
| 9c. COUNTY OF DEATH<br>MONTGOMERY   |  |   |  | 10a. STATE<br>DC  |  | 10b. COUNTY<br>NONE  |   |
| 10c. CITY, TOWN OR LOCATION<br>WASHINGTON   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   |
| 10e. STREET AND NUMBER<br>2700-MARTIN LUTHER KING JR., S.E.   |  |   |  | 10f. ZIP CODE<br>20032  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>AT HOME   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM HENRY YOUNG  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ETHEL FRANCES COLEMAN  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>REV. DR. REICHARD   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9701- VEIRS DR., ROCKVILLE, MD. 20850  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY-3/24-ALEXANDRIA, VA.  |  | 20c. LOCATION — City or Town, State   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. M. Hooper</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>HYSONG CO., INC.<br>1300-N ST., N.W., WASH., DC 20005   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary Artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate interval Between Onset and Death<br>2 Days<br>years   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Organic Brain Syndrome</i>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert W. Wooten, MD</i>  |  |   |  | 29c. LICENSE NUMBER<br>D42777   |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 22, 1996                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>15225 Shady Grove Road Rockville, MD   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 8 1996   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12333

|   |  |  |   |  |  |   |   |  |
|---|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lottie Thompson Jones</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>2</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>1:30 p.m.</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TAKOMA PARK</b>   |   | 4c. County of Death<br><b>PG</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>237-14-4909</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>4/18/13</b>                   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>  |  |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  |  |   |   |  |
|   | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>PG</b>  |  | 10c. City, Town or Location<br><b>North Brentwood</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>4514 40th St</b>  |  |   |  | 10f. Zip Code<br><b>20722</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Yrs</b> College (1-4or 5+) <b>2 yrs</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary (VA)</b>   |   | 16b. Kind of Business/Industry<br><b>Federal Government</b>             |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Carl T. Graham</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unk</b>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John H. Jones</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1222 Port-Echo Lane, Bowie, Md., 20716</b>   |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft Lincoln Cemetery</b>  |  | Date<br><b>4/6/96</b>  |   | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>            |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Philip J. Kay</b>  |  |   |  | 22. Name and Address of Facility<br><b>John T. Rhines Co., Inc.<br/>3030 12th St NE, DC 20017</b>  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. ISCHEMIC Cerebral Disease</b><br>Due to (or as a consequence of):<br><b>c. ARTERIOsclerotic Cerebro-Vascular</b><br>Due to (or as a consequence of):<br><b>d. HYPERTENSION, DIABETES MELLITUS AND HYPERcholesterolemia</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>WITH COMATOSE STATE</b><br><b>DR</b><br><b>AND</b><br><b>ANEMIA</b><br><br>Approximate Interval Between Onset and Death<br><b>SEVERAL WEEKS</b><br><b>MONTHS</b> |  |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>① CHRONIC RENAL FAILURE - ON DIALYSIS</b><br><b>② CORONARY HEART DISEASE</b><br><b>③ SEVERE ANEMIA</b><br><b>④ SEIZURE DISORDER</b><br><b>⑤ OCCLUSIVE PERIPHERAL VASCULAR DISEASE WITH GANGRENE OF LEFT FOOT.</b>  |  |  |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how Injury occurred   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Mohammed A. Mannan MD</b>   |  |  |   | 29c. License number<br><b>D24593</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/2/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MOHAMMED A. MANNAN MD, 3715-RHODE ISLAND AVE<br/>MT. RAINIER, MD. 20712</b>  |  |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1996</b>   |  |  |   | 32. Registrar's Signature<br><b>John M. ...</b>  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12334

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL ANTHONY JOHNSON

2. Date of Death

April 4 1996

Day

Year

3. Time of Death

11:20Am

4a. Facility Name (If not institution, give street and number)

2601 Afton Street

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

219-35-6236

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

6/11/68

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Md

10b. County

PG

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2601 Afton Street

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

Single

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Special Education

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A (Disabled)

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Morris Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Butler

19a. Informant's Name/Relationship (Type, Print)

Sylvia Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10a,b,c,d,e &amp; f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

4/8/96

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Juan Simell

22. Name and Address of Facility

John T. Rhines, Co., Inc.  
3030 12th St NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Palsy, with complications  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

bronchitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D25925

29d. Date signed (Month, Day, Year)

April 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205, 7720 WISCONSIN Ave, Bethesda, Md 20814

31. Date filed (Month, Day, Year)

APR 08 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12335

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CURTIS A JONES

2. Date of Death

Month Day Year  
APRIL 4 1996

3. Time of Death

3:20 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Centre

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

415-13-3412

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 10, 1961

9. Birthplace (State or Foreign Country)

Tennessee

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Cheverly

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3405 Laurel Avenue

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Curtis Jones

18. Mother's Name (First, Middle, Maiden Surname)

Jean Craig

19a. Informant's Name/Relationship (Type, Print)

Jean Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3405 Laurel Ave. Cheverly, MD. 20785

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

crematory, crematory or other place)

Chesapeake Crematory

Date

1996

April 8

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Kimberly C. Busch-Tonic

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acquired Immuno-Deficiency Syndrome

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28b. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Berger

29c. License number

D25925

29d. Date signed (Month, Day, Year)

April 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205, 7720 WISCONSIN AVE., Bethesda, Md 20814

31. Date filed (Month, Day, Year)

APR 09 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12336

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Timothy Lee Jestes</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>9</b> Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>3:45 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1307 Damacus Street</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Odenton</b>   |  |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-82-6814</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 27, 1961</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Odenton</b>  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>1307 Damascus Street</b>   |  |   |  | 10f. Zip Code<br><b>21113</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                    |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Joseph Edward Jestes, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maryland Elizabeth Tucker</b>  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Jestes, Sr.-Brother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8602 Holly Street, Laurel, MD 20707</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Funeral Service</b>   |  | Date<br><b>April 9, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                                |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Debra Rendon</b>  |  | 22. Name and Address of Facility<br><b>Columbia Mortuary Services, Inc.<br/>225 Missouri Ave., N.W., Washington, DC 20011</b>   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br><b>b. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 Months</b><br><b>5 Years</b>              |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>23b. Did tobacco use contribute to the cause of death?</b><br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown<br><br><b>24a. Was an autopsy performed?</b><br><b>1</b> Yes <b>2</b> No<br><br><b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><b>1</b> Yes <b>2</b> No   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Howard A. Stark</b>   |  | 29c. License number<br><b>D35823</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 9, 1996</b>                                 |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Howard A. Stark, MD, 2311 M Street, NW, Suite 302, Washington, DC 20037</b>  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>APR 11 1996</b>   |  | 32. Registrar's Signature<br><b>John A. Anderson</b>  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

SEP 11 1964

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State of Maryland / Department of Health and Mental Hygiene

96 12337

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY VIOLA KRETSINGER

2. Date of Death

Month

Day

Year

April

16, 1996

3. Time of Death

16:09

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-16-1587

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 13, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

326 Belview Avenue

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Person

16b. Kind of Business/Industry

Aircraft Mfg.

17. Father's Name (First, Middle, Last)

Clarence W. Gladhill

18. Mother's Name (First, Middle, Maiden Surname)

Bessie V. Mills

19e. Informant's Name/Relationship (Type, Print)

Stanley L. Kretsinger/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

326 Belview Avenue, Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 04/19/96

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. North, Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ASTHMATIC BRONCHITIS -

YEARS

Due to (or as a consequence of):

b.

OSTEOPOROSIS

"

Due to (or as a consequence of):

c.

VERTEBRAL COMPRESSION FRACTURES - 1-2 yr

Due to (or as a consequence of):

d.

DEEP VEIN THROMBOSIS - @ LEG.

2 MONTHS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1299 HOWELL RD HAGERST MD 21740.

31. Date filed (Month, Day, Year)

APR 18 1996

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

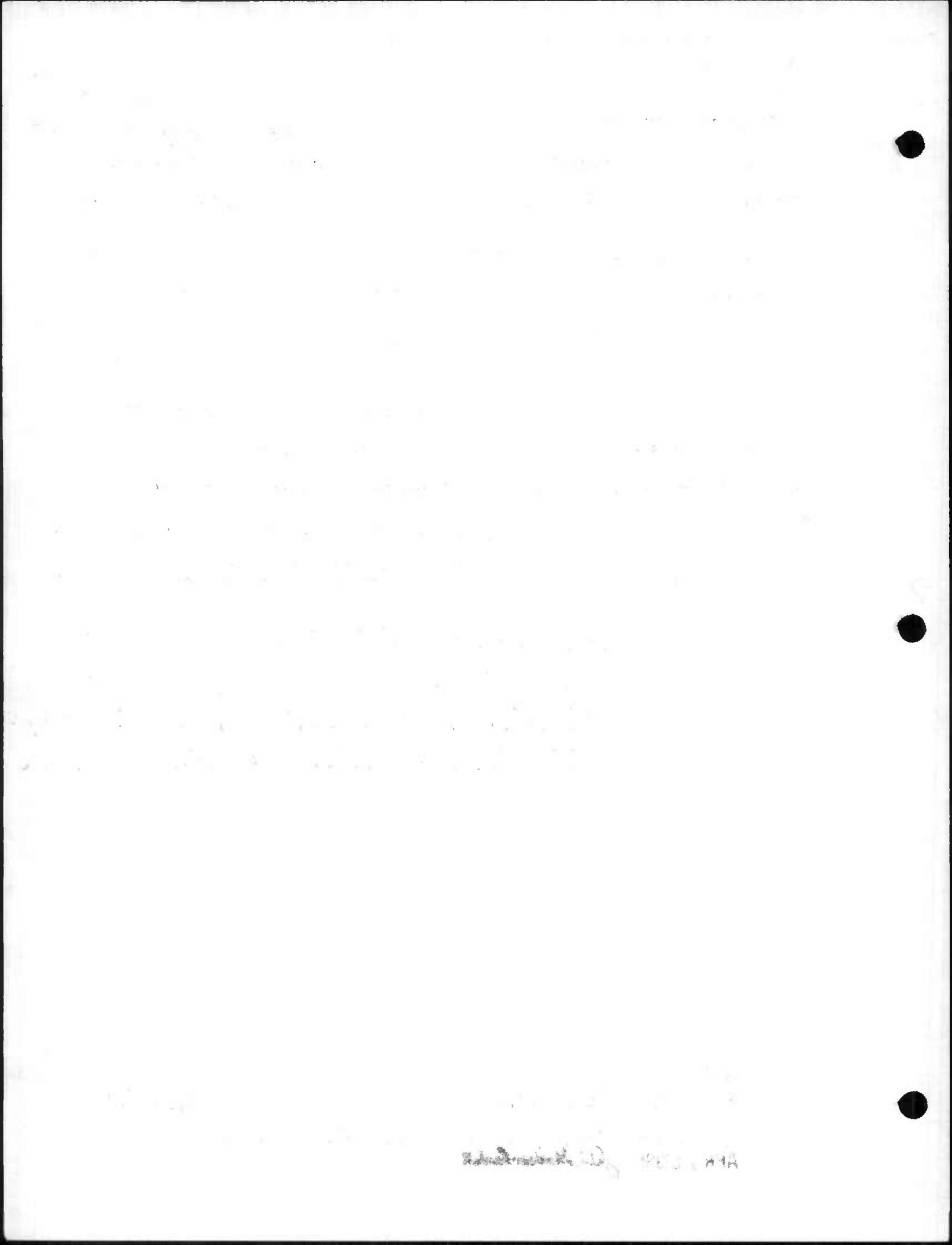
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12338

## Certificate of Death

Reg. No.

|   |  |                         |   |   |   |  |   |   |
|---|--|-------------------------|---|---|---|--|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Chester Franklin Keefer  |                         |   |   | 2. Date of Death<br>Month: April Day: 10 Year: 1996   |  | 3. Time of Death<br>10:45 am  |   |
|   | 4e. Facility Name (If not institution, give street and number)<br>Washington County Hospital   |                         |   |   | 4b. City, Town, or Location of Death<br>Hagerstown  |  | 4c. County of Death<br>Washington   |   |
| Funeral<br>Director                           | 5. Social Security Number<br>209 12 6843   |                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>70 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Feb. 14, 1926                                     | 9. Birthplace (State or Foreign Country)<br>Mercersburg, PA |
|   | Usual Residence of Decedent  |                         |   |   |   |  |   |   |
| To Be Completed by Funeral Director           | 10e. State<br>PA   | 10b. County<br>Franklin | 10c. City, Town or Location<br>State Line   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br>15615 Pennsylvania Ave.  |                         |   | 10f. Zip Code<br>17263                    |   | 10g. Citizen of What Country?<br>U S   |   |   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                            |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)   |                         | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Owner                             |   | 16b. Kind of Business/Industry<br>Keefer Mobile Home Supplies   |  |   |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Harvey Keefer   |                         |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eva Thomas Keefer Ricker   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Nellie E. Keefer/spouse   |                         |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15615 Pennsylvania Ave., State Line, PA 17263  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |   | Date<br>4/13/96   |  | 20c. Location - City or Town, State<br>Greencastle, PA                                      |   |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |                         |   |   | 22. Name and Address of Facility<br>Minnich-Miller-May Funeral Home, 521 S. Washington St., Greencastle, PA 17225   |  |   |   |
| To Be Completed by Physician/Medical Examiner | 23e. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Ischemic Heart Disease</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>years |                         |   |   |   |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Pulmonary Embolism</u>  |                         |   |   |   |  |   |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                         |   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |                         | 28e. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                         | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>0214571  |  | 29d. Date signed (Month, Day, Year)<br>4/10/96  |   |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>ABDUL WAHED, MD - 12821 - OAKHILL AVE HAGERSTOWN, MD   |                         |   |   |   |  |   |   |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>APR 12 1996   |                         | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |   |   |



96 12339

DMMH 16 Rev 6/95



96 12340

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |  |
|--|--|--|--|--|--|---|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Thomas Joseph Kohler Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>7</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>5:20 P M</b>   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>235-42-9513</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 13, 1929</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>   |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |   |  |
| RESIDENCE OF DECEASED  |  |  |  |  |  |   |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>12405 Snyder Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>21502</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1946-1949</b> |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |   |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Contractor Salesman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lowe's</b>   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas J. Kohler, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Geraldine F. (Buckley)</b>   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rose Marie Kohler</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12405 Snyder Drive; LaVale, MD 21502</b>   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cem 04/11</b>   |  | 20c. LOCATION — City or Town, State<br><b>Flintstone, MD</b>   |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James F. Scarpelli</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Dysrhythmia</b>   |  |  |  |  |  |   |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |  |
| b. <b>Acute Myocardial Infarction</b>  |  |  |  |  |  |   |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>   |  |  |  |  |  |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |   |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jesus Tan</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>021244</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/8/96</b>  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Jesus Tan; Frostburg Plaza; Frostburg, MD 21532</b>  |  |  |  |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew K...</i>   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12341

## Certificate of Death

Reg. No.

Amended #12, 4/8/96,  
NKS, Allegany County

|  |  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|--|--|---|---|--|--|--|--|--|---|--|----------------|----------------------------------|--|---------------------|----------------|----------------------------------|--|-----------------------------|----------------|----------------------------------|--|------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Leo H. Kenney</b>   |   |   |  | 2. Date of Death<br>Month <b>4</b> Day <b>1</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>4:34 pm</b>   |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA - Baltimore</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore City</b>   |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-24-0700</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 25, 1929</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b> |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>Allegany</b>                                    | 10c. City, Town or Location<br><b>Cumberland</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 10e. Street and Number<br><b>211 Maryland Avenue</b>   |   |   | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korea</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Glass Cutter</b> |  | 16b. Kind of Business/Industry<br><b>Glass Manufacturer</b>                                    |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 17. Father's Name (First, Middle, Last)<br><b>Patrick Kennedy</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie (Burns)</b>   |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores M. Richard</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>511 Welch Avenue Cumberland, MD. 21502</b>   |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cemetery 4/8</b>  |  | 20c. Location - City or Town, State<br><b>Cumberland, MD.</b>  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 21. Signature of Funeral Service Licensee<br><i>William Skiff</i>  |   | 22. Name and Address of Facility<br><b>Kight Funeral Home<br/>309-311 Decatur St., Cumberland, MD. 21502</b>  |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | <table border="0"> <tr> <td rowspan="4">           Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Septic Shock, Multiple Organ Failure</b></td> <td><b>2 weeks</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Pneumonia</b></td> <td><b>2 weeks</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>Gastric Tube Leak</b></td> <td><b>23 days</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. <b>Esophageal Cancer.</b></td> <td><b>5 months</b></td> </tr> </table> |   |   |  |  |  |  |  | Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>Septic Shock, Multiple Organ Failure</b> | <b>2 weeks</b> | Due to (or as a consequence of): |  | b. <b>Pneumonia</b> | <b>2 weeks</b> | Due to (or as a consequence of): |  | c. <b>Gastric Tube Leak</b> | <b>23 days</b> | Due to (or as a consequence of): |  | d. <b>Esophageal Cancer.</b> |
| Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a. <b>Septic Shock, Multiple Organ Failure</b>   | <b>2 weeks</b>  |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | b. <b>Pneumonia</b>  | <b>2 weeks</b>  |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| c. <b>Gastric Tube Leak</b>  | <b>23 days</b>   |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| Due to (or as a consequence of):   |  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| d. <b>Esophageal Cancer.</b>   | <b>5 months</b>  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Piece of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                      |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Joanna K. Chon MD</b> |   | 29c. License number<br><b>AU4176435AC2731</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/1/96</b>   |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Joanna K. Chon MD 22 S. Greene St Baltimore MD 21201</b>  |  |   |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1996</b>  |  | 32. Registrar's Signature<br><i>John Anderson-Rodriguez</i>       |   |  |  |  |  |  |   |  |                |                                  |  |                     |                |                                  |  |                             |                |                                  |  |                              |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-698-2028.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12342

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DORA Edith KILLIUS   |   |   |   | 2. Date of Death<br>Month Day Year<br>April 15, 1996   |  | 3. Time of Death<br>10:10 AM                                     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital & Medical Center   |   |   |   | 4b. City, Town, or Location of Death<br>Cumberland   |  | 4c. County of Death<br>Allegany                                  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-28-0020   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec. 22, 1910             | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>Garrett  |   | 10c. City, Town or Location<br>Grantsville   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>1195 Springs Road  |   |   |   | 10f. Zip Code<br>21536   |  | 10g. Citizen of What Country?<br>USA                             |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |   |  | 18b. Kind of Business/Industry<br>Own Home   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Milton E. Wiley   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ellen E. Arnold   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Wilma Kipp, Daughter   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 672; Grantsville, Maryland 21536   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Springs Cemetery  |   | Date<br>April 18   |  | 20c. Location - City or Town, State<br>Springs, PA               |  |  |
|   | 21. Signature of Funeral Service Licensee<br>D. Lynn Newman  |   |   |   | 22. Name and Address of Facility<br>Newman Funeral Homes, P.A.; P.O. Box 275<br>Grantsville, Maryland 21536  |  |  |  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular accident<br>Due to (or as a consequence of):<br>b. Hypertension<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>4 days<br>4 days.  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>Subendocardial myocardial infarction, Hyponatremia,<br>Non-obstructive cardiomyopathy<br>Chronic Atrial Fibrillation   |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)                           |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and Title of Certifier<br>Dr. Narayan Saheta MD. |   | 29c. License number<br>D17920   |  | 29d. Date signed (Month, Day, Year)<br>April 16, 1996                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Narayan Saheta Memorial Hospital Cumberland, MD. 21502  |  |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 18 1996  |  | 32. Registrar's Signature<br>John Davidson-Randall              |   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

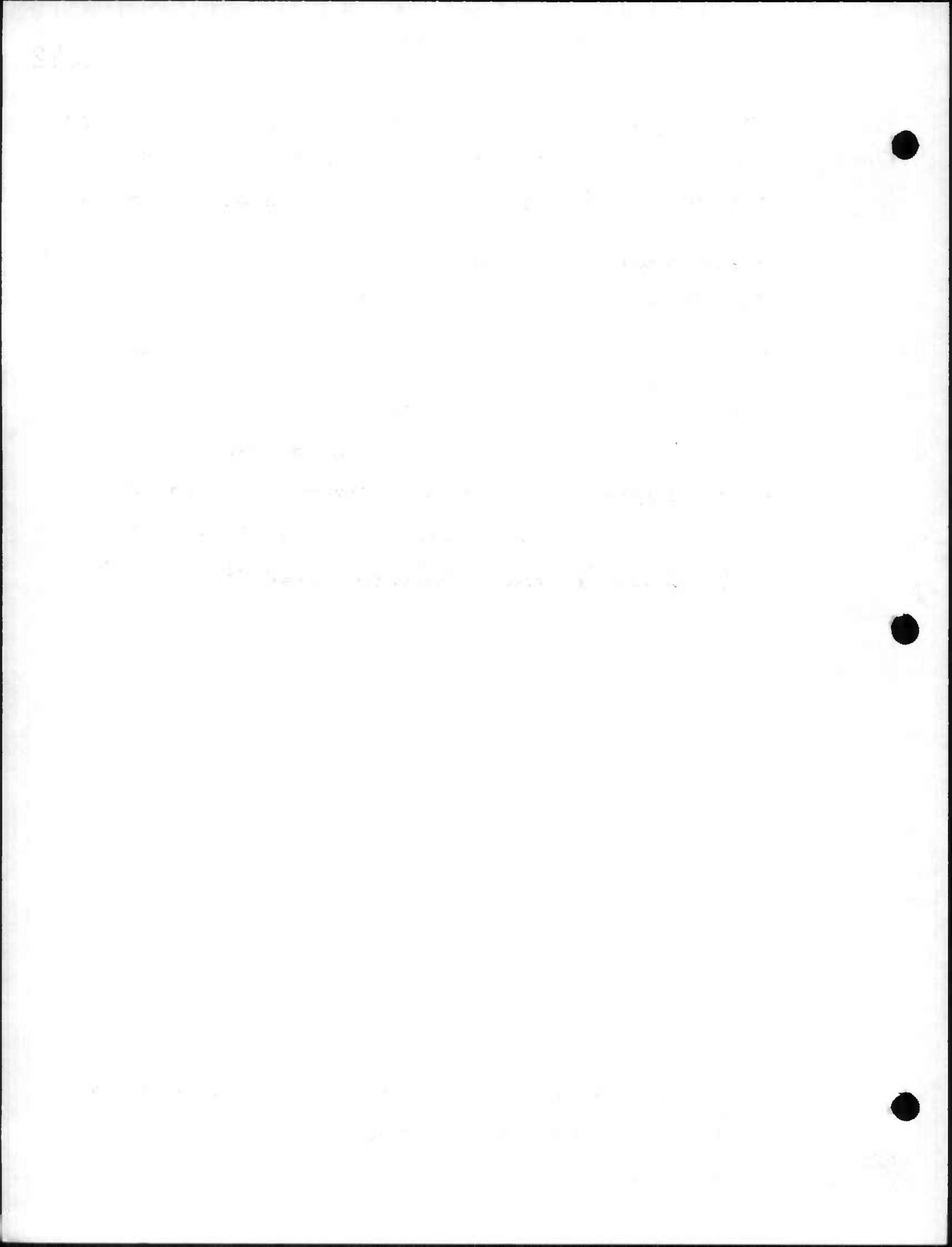
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



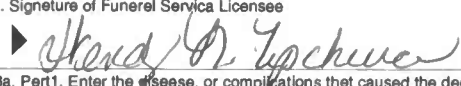
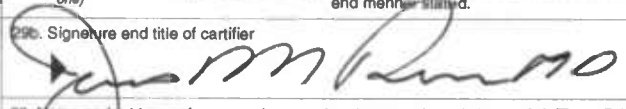
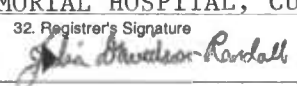
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12343

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |   |  |
|--|--|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MERVIN H. KYLE   |   |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 15 1996  |   | 3. Time of Death<br>6:34 P   |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MEMORIAL HOSPITAL  |   |   |  | 4b. City, Town, or Location of Death<br>CUMBERLAND   |   | 4c. County of Death<br>ALLEGANY  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>236-03-3954   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.                                    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>JUNE 16, 1916   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |   |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>WEST VA  |   | 10b. County<br>MINERAL  |  | 10c. City, Town or Location<br>RIDGELEY  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br>4 MARYLAND STREET  |   |   |  | 10f. Zip Code<br>26753   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942-1946 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>UNKNOWN   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>COOK   |  | 16b. Kind of Business/Industry<br>RESTAURANT   |   |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>JOHN EDGAR KYLE   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARGARET FOOTEN   |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>DEBBIE SELF  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. BOX 836 - RIDGELEY, WEST VIRGINIA 26753  |   |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>RESILAWN MEMORIAL GARDENS   |  | Date<br>4/19/96  |   | 20c. Location - City or Town, State<br>LAVALE, MARYLAND  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br>202 GREENE STREET, CUMBERLAND, MD 21502  |   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Sepsis syndrome<br>Due to (or as a consequence of):<br><br>b. Small bowel obstruction<br>Due to (or as a consequence of):<br><br>c. Pneumonia, aspiration<br>Due to (or as a consequence of):<br><br>d. |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>14 days<br>25 days<br>20 days |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Malnutrition   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>D 18769   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 18 1996  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>JAMES RAVEN M.D., MEMORIAL HOSPITAL, CUMBERLAND, MD 21502  |  |   |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 18 1996   |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12344

## Certificate of Death

Reg. No.

|  |   |   |   |                                |  |  |   |  |  |
|--|---|---|---|--------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ANNA MATILDA KNIPPENBERG  |   |   |                                | 2. Date of Death<br>Month Day Year<br>APRIL 12 1996  |  | 3. Time of Death<br>15:20   |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>MEMORIAL HOSPITAL & MEDICAL CENTER  |   |   |                                | 4b. City, Town, or Location of Death<br>CUMBERLAND   |  | 4c. County of Death<br>ALLEGANY   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-60-0174  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>71 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>JULY 19 1924  | 9. Birthplace (State or Foreign Country)<br>PA.   |  |  |
|  | Usual Residence of Decedent   |   |   |                                |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  | 10b. County<br>ALLEGANY   | 10c. City, Town or Location<br>CUMBERLAND   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
|  | 10e. Street and Number<br>12703 MOORES HOLLOW ROAD S.E.   |   |   | 10f. Zip Code<br>21502         |  | 10g. Citizen of What Country?<br>U.S.A.  |   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSE KEEPER                             |                                |  | 16b. Kind of Business/Industry<br>HOUSE KEEPER   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>GEORGE WILLIAM DOM   |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY SUDER  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>DELBERT G. KNIPPENBERG HUSBAND  |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12703 MOORES HOLLOW ROAD S.E. CUMBERLAND MARYLAND   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. HERMON CEMETERY   |                                | Data<br>APRIL 15 1996  |  | 20c. Location - City or Town, State<br>CUMBERLAND MARYLAND  |  |  |
|  | 21. Signature of Funeral Service Location<br><i>Stale L. Merritt</i>  |   |   |                                | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME<br>404 DECATUR STREET CUMBERLAND MARYLAND   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Colon Cancer<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                |  |  |   | Approximate Interval Between Onset and Death<br>4 Years  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |                                |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                                |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Richard L. Snider, M.D.</i>   |   | 29c. License number<br>D 17246 |  | 29d. Date signed (Month, Day, Year)<br>APRIL 15 1996   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. RICHARD SNIDER, MEMORIAL HOSPITAL, SUITE 402, CUMBERLAND, MD 21502   |   |   |   |                                |  |  |   |  |  |
| 31. Date of Death (Month, Day, Year)<br>APR 15 1996  |   | 32. Registrar's Signature<br><i>John A. Harrison</i>  |   |                                |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



96 12345

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Sara Warrington</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 11, 1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>1855</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-20-8516</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 23, 1926</b>                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>Crusader Arms Apts.<br/>Apt. 802, 214 Meteor Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerical</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>County Government</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Casper</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances Spedden</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Lloyd Warrington</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3405 Cedar Lane, East New Market, MD. 21631</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dorchester Mem. Pk. 4-16</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, MD.</b>  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Curran-Bromwell Funeral Home, P.A.<br/>308 High St., Cambridge, MD. 21613</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>Yrs</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b>1</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen Pavlos</i>   |  | 29c. LICENSE NUMBER<br><b>D 41721</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/12/96</b>                                |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen Pavlos M.D. 560 RIVERSIDE DR. B101 SALISBURY, MD 21801</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 16 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12346

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Francis Kennedy

2. Date of Death

Month April 3, Day 1996 Year

3. Time of Death

5:41 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

578-03-2595

6. Sex

100 M 200 F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Sept. 12, Day 1909 Year

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Myersville

10d. Inside City Limits

100 Yes 200 No

10e. Street and Number

11627 Wolfsville Road

10f. Zip Code

21773

10g. Citizen of What Country?

U.S.A.

11. Marital Status

100 Never Married 200 Married  
300 Widowed 400 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

100 Yes 200 No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

100 Yes 200 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

District Manager

16b. Kind of Business/Industry

Exxon

17. Father's Name (First, Middle, Last)

Patrick Kennedy

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Martin

19a. Informant's Name/Relationship (Type, Print)

Ethel G. Kennedy / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11627 Wolfsville Road, Myersville, Maryland 21773

20a. Method of Disposition

100 Burial 200 Cremation 300 Removal from State  
400 Donation 500 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

4/6

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. (Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

100 Yes 200 No 300 Probably 400 Unknown

24a. Was an autopsy performed?

100 Yes 200 No

24b. Were autopsy findings available prior to completion of cause of death?

100 Yes 200 No

25. Was case referred to medical examiner?

100 Yes 200 No

Hospital:

100 Inpatient

200 Outpatient

300 DOA

26. Place of Death (Check only one)

Other:

400 Nursing Home

500 Residence

600 Other (Specify)

27. Manner of Death

100 Natural 500 Pending investigation  
200 Accident 600 Could not be determined  
300 Suicide  
400 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

100 Yes 200 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

100

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D16498

29d. Dated signed (Month, Day, Year)

4/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III, MD 300 West Ninth Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

APR 04 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12347

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY

KAMEN

2. Date of Death

Month Day Year  
March 28, 1996

3. Time of Death

8:40AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

14621 Deerhurst Terrace

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

064-07-5918

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1/18/1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1X Yes 2□ No

10e. Street and Number

14621 Deerhurst Terrace

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2X Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

X Yes 2□ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Governmentworker

16b. Kind of Business/Industry

Department of

Navy

17. Father's Name (First, Middle, Last)

Morris Silverman

18. Mother's Name (First, Middle, Maiden Surname)

Bella Deiber

19a. Informant's Name/Relationship (Type, Print)

Patricia Kamien

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14621 Deerhurst Terr., Sil. Spr. MD. 20906

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State

X□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Georgetown Med. Sch. 3/28/96 Washington, D.C.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Austin Royster Funeral Home

3605 14th St., N.W. Wash, D.C. 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer

2 weeks

Due to (or as a consequence of):

e.

Chronic obstructive Lung Disease

5 years

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

Coronary Artery Disease

Cerebral vascular Accident

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1□ Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6X Other (Specify) Home

27. Manner of Death

X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18726

29d. Date signed (Month, Day, Year)

MARCH 29, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

18111 Prince Philip Dr, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

APR 08 1996

32. Registrar's Signature

John Andrew Harsh

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12-11-71

12-11-71

12-11-71

12-11-71 3200 3 6 99A

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dallas Willard KEHNE, JR.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 25, 1996   |  | 3. TIME OF DEATH<br>3:20 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-36-2678   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>April 16, 1911   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>5307 Mussetter Road  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Ijamsville  |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Ijamsville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5307 Mussetter Road  |  |
| 10f. ZIP CODE<br>21754   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Farmer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dairy Farm   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Dallas Willard Kehne, Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lula Main   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Martha V. Kehne   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5307 Mussetter Road, Ijamsville, Maryland 21754   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery, March 28, 1996   |  | 20c. LOCATION — City or Town, State<br>Frederick, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lubard C. Basford</i> M00021   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford P.A. Funeral Home<br>106 East Church St., Frederick, MD 21701   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. Aortic Valve Disease  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atrial Fibrillation  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kerry Teplinsky</i>  |  |  |  | 29c. LICENSE NUMBER<br>D44079  |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 26, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Kerry Teplinsky, M.D., 915 Tollhouse Avenue, Frederick, MD 21701  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 28 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

57

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12349

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLENN D. LONGENECKER

2. Date of Death

Month Day Year  
APRIL 14, 1996

3. Time of Death

1224

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

300-18-3683

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

5-27-12

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

Md.

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 SANDPIPER LASNE

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ANALYST

16b. Kind of Business/Industry

USG NSA

17. Father's Name (First, Middle, Last)

CHARLES C. LONGENECKER

18. Mother's Name (First, Middle, Maiden Summa)

CLARA MERGLER

19a. Informant's Name/Relationship (Type, Print)

IDA CAMPBELL LONGENECKER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2545 OCEAN PINES BERLIN, MD., 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

4-15

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD., 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Infection  
Due to (or as a consequence of):b. Cardiac Failure  
Due to (or as a consequence of):c. Lung Failure  
Due to (or as a consequence of):d. Kidney Failure  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baiter WOLFE MARY 9733 NEARBYWAY DR. BERLIN, MD 21811

State Registrar

31. Date filed (Month, Day, Year)

APR 15 1996

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12350

## Certificate of Death

Reg. No.

|   |   |   |   |                                      |   |  |  |   |  |  |
|---|---|---|---|--------------------------------------|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Kathleen Lois Lisse</i>  |   |   |                                      |   |  | 2. Date of Death<br>Month <i>April</i> Day <i>15</i> Year <i>1996</i>    |   | 3. Time of Death<br><i>7:00 AM</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Washington County Hospital</i>   |   |   |                                      |   |  | 4b. City, Town, or Location of Death<br><i>Hagerstown</i>                |   | 4c. County of Death<br><i>Washington</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>020-22-5067</i>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><i>68</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Feb. 24, 1928</i>              |   | 9. Birthplace (State or Foreign Country)<br><i>New York</i>  |  |
|   | Usual Residence of Decedent   |   |   |                                      |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>Washington</i>  |                                      | 10c. City, Town or Location<br><i>Hagerstown</i>  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><i>1149 Potomac Avenue</i>  |   |   |                                      | 10f. Zip Code<br><i>21742</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                           |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>2 Years</i> College (1-4 or 5+) <i>2 Years</i>  |   |   |                                      | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Computer Operator</i>   |  |  | 16b. Kind of Business/Industry<br><i>Retail Dept. Store</i>             |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Ralph D. McGANN</i>   |   |   |                                      |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mae M. Coons</i> |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Douglas Lisse/Son</i>  |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3621 McBryde Ave., Richmond, Cal. 94805</i>   |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory</i>   |                                      | Date<br><i>4/15/96</i>  |  | 20c. Location - City or Town, State<br><i>Smithsburg, Maryland</i>       |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Douglas A. Fiery</i>  |   |   |                                      | 22. Name and Address of Facility<br><i>21742 1331 Eastern Blvd. N<br/>Douglas A. Fiery Funeral Home Hagerstown, MD</i>  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Carcinoma of breast</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |   |   |                                      |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |                                      |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                                      |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |                                      |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |                                      |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                      |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><i>M</i>      |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                      |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |                                      |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Frederic H. Lisse MD</i>  |   |   |   | 29c. License number<br><i>A23623</i> |   |  | 29d. Date signed (Month, Day, Year)<br><i>4/15/96</i>                    |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Frederic H. Lisse MD 1799 Howell Rd Hagerstown</i>   |   |   |   |                                      |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 15 1996</i>   |   | 32. Registrar's Signature<br><i>John A. ...</i>   |   |                                      |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

7. 2. 1944

96 12351

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELLA I LLEWELLYN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 3, 1996   |  | 3. TIME OF DEATH<br>11:55 p M   |   |
| 4. SOCIAL SECURITY NUMBER<br>213-48-7498   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>93 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>October 22 1902  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Memorial Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland   |  | 9c. COUNTY OF DEATH<br>Allegany   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Allegany  |  | 10c. CITY, TOWN OR LOCATION<br>Barton   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>18017 Lower Georges Creek Rd.  |  |  |  | 10f. ZIP CODE<br>21521  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Clark   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Hannah Poland  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Viola Hilleary   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1251 Braddock Rd. LaVale, Md. 21502  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Laurel Hill Cem. 4-6-96   |  | 20c. LOCATION — City or Town, State<br>Barton, Md.  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wayne Boal</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Boal Funeral Home<br>111 Church St. Westernport, Md.  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Atherosclerotic Coronary Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF): 50 years<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Diabetes Mellitus<br>DUE TO (OR AS A CONSEQUENCE OF): Unknown<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Intertrochanteric Fracture Right Hip.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John R. Starynski MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D 33240  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 5, 1996  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. John Starynski-Johnson Heights Medical Building-Cumberland, MD 21502  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 10 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Starynski</i>  |  |   |   |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.6  
etc



96 12352

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY M. LYON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>24</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>10:15A</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>235-82-4882</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan 31, 1920</b>              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL &amp; MEDICAL CTR.</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>                                     |   |
| 10a. STATE<br><b>WV</b>  |  |   |  | 10b. COUNTY<br><b>Mineral</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Keyser</b>                               |   |
| 10d. INSIDE CITY LIMITS?<br>t <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>1450 Funderburg Street</b>  |  |   |  | 10f. ZIP CODE<br><b>26726</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lorenzo Dow Fleming</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lula Frances Harrison</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy L. Lyon</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1450 Funderburg Street Keyser, WV 26726</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Thrush Cemetery</b>   |  | DATE<br><b>Mar 27 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Antioch, WV</b>                  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rotruck-Smith Funeral Home</b><br><b>85 South MAIN Street Keyser, WV 26726</b>   |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Cardiogenic Shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Acute Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>6 Hours</b><br><b>6 Hours</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>S/P Coronary Artery Bypass Graft. Non-Insulin Dependent</b><br><b>Chronic Mitral Regurgitation. Diabetes</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 20258</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>MARCH 29 1996</b>                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. SURESH SHRESTHA, MEMORIAL HOSPITAL, CUMBERLAND, MD 21502</b>   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 04 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12353

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARY FRANCES LARRY   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 11, 1996   |  | 3. Time of Death<br>11:58 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital Medical Center   |  |   |   | 4b. City, Town, or Location of Death<br>Cumberland   |  | 4c. County of Death<br>Allegany  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-28-6391   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>63 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth (Month, Day, Year)<br>Jul 27, 1932                                  | 9. Birthplace (State or Foreign Country)<br>MD   |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |  | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Cumberland  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 10e. Street and Number<br>617 Sedgwick Street  |  |   |   | 10f. Zip Code<br>21502   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Clerk  |   |  | 16b. Kind of Business/Industry<br>Sears                |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Joseph Bernard McCabe   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elva (Nicklow)  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Greg Larry--son  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>619 Fairview Avenue; Cumberland, MD 21502   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Peter's Cemetery  |   | Date<br>04/15  | 20c. Location - City or Town, State<br>Westernport, MD |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Nicholas J. Scarpelli   |  |   |   | 22. Name and Address of Facility<br>Scarpelli Funeral Home<br>Cumberland, MD 21502   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEPSIS<br>Due to (or as a consequence of):<br>b. PSEUDOMONAS PERITONITIS<br>Due to (or as a consequence of):<br>c. Peritoneal dialysis<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>chronic renal failure, Diabetes Mellitus, anemia<br>Diabetic Mellitus, renal transplant rejection |  |  |   |   |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br>N. A. Ranjithan   |  |   |   | 29c. License number<br>D19318  |  | 29d. Date signed (Month, Day, Year)<br>April 12 1996                                 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. N. Ranjithan 517 Oldtown Road Cumberland, MD, 21502  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1996  |  |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12354

## Certificate of Death

Reg. No.

|   |  |                           |   |   |  |  |                                |  |                                   |  |   |   |  |  |
|---|--|---------------------------|---|---|--|--|--------------------------------|--|-----------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Cameron David LEWIS                        |                           |   |   | 2. Date of Death<br>Month Day Year<br>April 16, 1996 |  |                                |  | 3. Time of Death<br>5:10 AM       |  |   |   |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>1908 Applewood Drive |                           |   |   | 4b. City, Town, or Location of Death<br>Hagerstown   |  |                                |  | 4c. County of Death<br>Washington |  |   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>058-12-3358   |                           | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>75 Yrs.            |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.    |  | 8. Date of Birth (Month, Day, Year)<br>June 1, 1920 |   | 9. Birthplace (State or Foreign Country)<br>Virginia |  |
|   | Usual Residence of Decedent  |                           |   |   |  |  |                                |  |                                   |  |   |   |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Washington |   | 10c. City, Town or Location<br>Hagerstown   |  |  |                                |  |                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |
| 10e. Street and Number<br>1908 Applewood Drive  |  |                           |   |   |  | 10f. Zip Code<br>21742   |                                |  |                                   | 10g. Citizen of What Country?<br>USA   |   |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 9   |  |                           |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>research chemist  |                                |  |                                   | 16b. Kind of Business/Industry<br>chemical company   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Edgar Lewis  |  |                           |   |   |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carmela Cameron   |                                   |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Norma J. Lewis  |  |                           |   |   |  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1908 Applewood Dr., Hagerstown, Md. 21742 |                                   |  |   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory  |  |  |                                | Date<br>4-16-96  |                                   | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnick</i>  |  |                           |   |   |  |  |                                | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740                                     |                                   |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Prostate Cancer<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                           |   |   |  |  |                                |  |                                   |  |   | Approximate Interval Between Onset and Death<br>2 years   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |   |  |  |                                |  |                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |  |
|   |  |                           |   |   |  |  |                                |  |                                   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |                                   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |                           |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                   | 28d. Describe how injury occurred  |   |   |  |  |
|   |  |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                           |   | 29b. Signature and title of certifier<br><i>Michael J. McCormack</i>  |  |  |                                | 29c. License number<br>041667  |                                   | 29d. Date signed (Month, Day, Year)<br>4.16.96   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>1799 Howell Rd Hagerstown MD 21740  |  |                           |   |   |  |  |                                |  |                                   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 17 1996  |  |                           |   | 32. Registrar's Signature<br><i>J. H. ...</i>   |  |  |                                |  |                                   |  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9056.

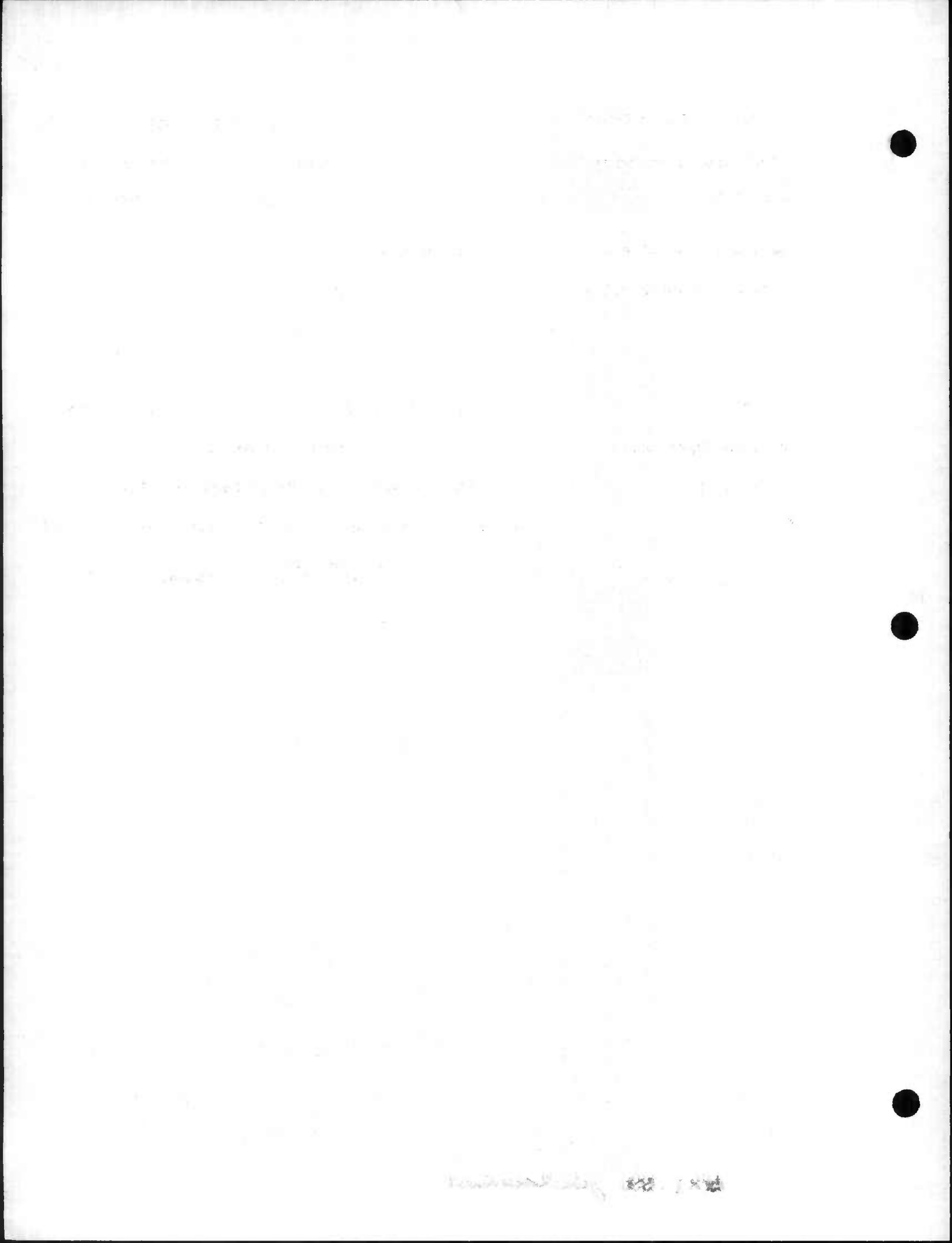
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12355

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |   |  |  |
|---|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RALPH, JOSEPH, LIPELLA</b>                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 10, 1996</b> |   | 3. Time of Death<br><b>17:56</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>    |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>156-01-6506</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>January 26, 1917</b>                              | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |
|   | Usual Residence of Decedent   |   |  |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>18511 Old Colony Lane</b>  |   |   |  | 10f. Zip Code<br><b>21742</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>W.W.II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>  |   |   | 16b. Kind of Business/Industry<br><b>Truck Mfg.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Lipella</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carmella Rosa</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Marguerite Lipella</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18511 Old Colony Lane Hagerstown, Maryland 21742</b>                                     |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park</b>   |  | Date<br><b>4-13-1996</b>   |   | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>                          |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd. N. Hagerstown, Maryland 21742</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |   |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ASYSTOLE</b><br>Due to (or as a consequence of):   |   |   |  |  |   |   |  | <b>ten minutes</b>   |
| b. <b>SEPSIS</b><br>Due to (or as a consequence of):  |   |   |  |  |   |   |  | <b>two days</b>  |
| c. <b>ENTEROCUTANEOUS FISTULA</b><br>Due to (or as a consequence of):   |   |   |  |  |   |   |  | <b>one month</b>   |
| d.  |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic Cardiovascular Disease</b><br><b>Recurrent small bowel obstruction</b><br><b>Short gut syndrome, urinary tract infection</b>   |   |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>M1344</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 10, 1996</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Rene Chambers MD Johns Hopkins Hospital Wolfe St, Balto, MD 21205</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>   |   |   |  |  |   |   |  |  |
| 32. Registrar's Signature<br>  |   |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $f(x)$  is an odd function and that  $f(x) \in C^1(\mathbb{R})$ .

2. In the second part, we consider the function  $g(x)$  defined by the equation

$$g(x) = \int_0^x \frac{t}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $g(x)$  is an even function and that  $g(x) \in C^1(\mathbb{R})$ .

3. In the third part, we consider the function  $h(x)$  defined by the equation

$$h(x) = \int_0^x \frac{t^2}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $h(x)$  is an even function and that  $h(x) \in C^1(\mathbb{R})$ .

4. In the fourth part, we consider the function  $k(x)$  defined by the equation

$$k(x) = \int_0^x \frac{t^3}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $k(x)$  is an odd function and that  $k(x) \in C^1(\mathbb{R})$ .

5. In the fifth part, we consider the function  $l(x)$  defined by the equation

$$l(x) = \int_0^x \frac{t^4}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $l(x)$  is an even function and that  $l(x) \in C^1(\mathbb{R})$ .

6. In the sixth part, we consider the function  $m(x)$  defined by the equation

$$m(x) = \int_0^x \frac{t^5}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $m(x)$  is an odd function and that  $m(x) \in C^1(\mathbb{R})$ .

7. In the seventh part, we consider the function  $n(x)$  defined by the equation

$$n(x) = \int_0^x \frac{t^6}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $n(x)$  is an even function and that  $n(x) \in C^1(\mathbb{R})$ .

8. In the eighth part, we consider the function  $o(x)$  defined by the equation

$$o(x) = \int_0^x \frac{t^7}{1+t^2} dt$$

for  $x \in \mathbb{R}$ . It is shown that  $o(x)$  is an odd function and that  $o(x) \in C^1(\mathbb{R})$ .

9. In the ninth part, we consider the function  $p(x)$  defined by the equation

$$p(x) = \int_0^x \frac{t^8}{1+t^2} dt$$

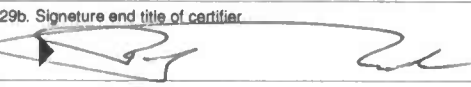
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12356

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|---|---|---|---|--|--|---|---|--|---|-------------------------------|----------------------------------|-------------|-----------------------------|----------------------------------|-------------|-------------------------------|----------------------------------|--------------|----|----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LUCILLE LORRAINE LEWIS</b>   |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>5</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>12:55 A.M.</b>                                   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>13711 Catoctin Hollow Rd.</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Thurmont</b>  |   | 4c. County of Death<br><b>Frederick</b>                                 |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-28-9027</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 28, 1933</b>             |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Thurmont</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 10e. Street and Number<br><b>13711 Catoctin Hollow Rd.</b>  |   |   |  | 10f. Zip Code<br><b>21788</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>                   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                    |  | 16b. Kind of Business/Industry<br><b>Clothing Company</b>  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edgar Lewis</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie M. Smith</b>  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Calvin R. Lewis (husband)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13711 Catoctin Hollow Rd. / Thurmont, Md. 21788</b>                                      |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Bethel Church Cem.</b>   |  | 20c. Location - City or Town, State<br><b>4-9-96 Foxville, Maryland</b>  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Home</b><br><b>104 E. Main St. / Thurmont, Maryland 21788</b>  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Respiratory failure</b></td> <td>Due to (or as a consequence of):</td> <td><b>1 mo</b></td> </tr> <tr> <td>b. <b>Lymphatic disease</b></td> <td>Due to (or as a consequence of):</td> <td><b>3 mo</b></td> </tr> <tr> <td>c. <b>Bacterial infection</b></td> <td>Due to (or as a consequence of):</td> <td><b>24 mo</b></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |  |  |   |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Respiratory failure</b> | Due to (or as a consequence of): | <b>1 mo</b> | b. <b>Lymphatic disease</b> | Due to (or as a consequence of): | <b>3 mo</b> | c. <b>Bacterial infection</b> | Due to (or as a consequence of): | <b>24 mo</b> | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Respiratory failure</b>   | Due to (or as a consequence of):  | <b>1 mo</b>   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | b. <b>Lymphatic disease</b>   | Due to (or as a consequence of):  | <b>3 mo</b>   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | c. <b>Bacterial infection</b>   | Due to (or as a consequence of):  | <b>24 mo</b>  |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   | d.  | Due to (or as a consequence of):  |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
|   |   | 28d. Describe how injury occurred   |   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>D 14626</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>Apr 5, 1996</b>                                   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>P. Gregory Rausch, 501 W. 7th St., / Frederick, Maryland 21701</b>   |   |   |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1996</b>   |   | 32. Registrar's Signature<br>  |   |  |  |   |   |  |   |                               |                                  |             |                             |                                  |             |                               |                                  |              |    |                                  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12357

## Certificate of Death

Reg. No.

|   |  |                                 |   |   |   |  |   |  |  |  |
|---|--|---------------------------------|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DUANE GROVER LAWRENCE</b>                       |                                 |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 3, 1996</b>                                  |  | 3. Time of Death<br><b>8:00 PM</b>                           |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>7300 Country Side Dr.</b> |                                 |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Middletown</b>                                   |  | 4c. County of Death<br><b>Frederick</b>                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-36-5220</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 11, 1920</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>S. Dakota</b> |  |
|   | Usual Residence of Decedent  |                                 |   |   |   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b> |   | 10c. City, Town or Location<br><b>Middletown</b>  |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>7300 Country Side Dr.</b>  |  |                                 |   | 10f. Zip Code<br><b>21769</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>W.W.II</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>   |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printing Pressman</b> |   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD KENT LAWRENCE</b>  |  |                                 |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MABEL HANSEN</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BETTY JEAN LAWRENCE (wife)</b>   |  |                                 |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7300 Country Side Dr. / Middletown, Maryland 21769</b> |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Johns Church Cemetery 4-9-96</b>   |   |   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                 |   |   |   | 22. Name and Address of Facility<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike / Frederick, Maryland 21702</b>                                     |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>12605 basis</b><br>Due to (or as a consequence of):<br>b. <b>acute myelocytic leukemia</b><br>Due to (or as a consequence of):<br>c. <b>myelodysplastic synd</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCD</b> |  |                                 |   |   |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                 |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                 |   |   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                                 | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                            |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                 | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D14626</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-4-96</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>P.G. Rousch, M.D. 501 W. 7th ST Frederick MD 21701</b>   |  |                                 |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1996</b>   |  |                                 | 32. Registrar's Signature<br>  |   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

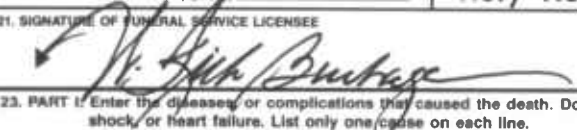
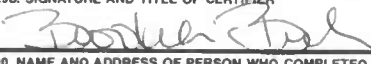
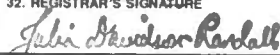
Medical Certification: To Be Completed by Physician/Medical Examiner





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                                     |   |   |   |  |  |  |
|---|--|---|--|---|-------------------------------------|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY SOPHIE MURAWSKI</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>12</b> YEAR <b>96</b>   |                                     | 3. TIME OF DEATH<br><b>11:50 P M</b>  |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>048-12-4215</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |                                     | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/8/17</b>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>CT</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>155 Sunshine Lane</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Ocean City</b>  |                                     |   |   | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |                                     |   |   |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Worcester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Ocean City</b>  |                                     |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>155 Sunshine Lane</b>  |  |   |  | 10f. ZIP CODE<br><b>21842</b>   |                                     | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                     |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>   |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b> |   |                                     | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Health Care</b>  |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Begay</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sophie Bujniak (HAFTEK)</b>   |                                     |   |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlene Cromwell</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4615 Arabia Ave. Baltimore, MD 21214</b>  |                                     |   |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cemetery 4/17/96 Baltimore, MD</b>  |  |   | 20c. LOCATION — City or Town, State |   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home<br/>108 Williams St. Berlin, MD 21811</b>   |                                     |   |   |   |  |  |  |
| 23. PART I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |                                     |   |   | Approximate interval Between Onset and Death  |  |  |  |
| PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |                                     |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |                                     |   |   |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                     |   |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |                                     | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                     | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |                                     |   |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  |   |                                     | 29c. LICENSE NUMBER<br><b>H44828</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/15/96</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Brookellen Bruley D.O 9300 Coastal Hwy Ocean City, Md 21842</b>   |  |   |  |   |                                     |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>4/16/96</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |                                     |   |   |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12359

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |                          |                                |  |                                  |  |   |   |  |  |
|--|--|---|--|---|---|--------------------------|--------------------------------|--|----------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>FLORA ALICE MAUCK                                  |   |  |   | 2. Date of Death<br>Month Day Year<br>April 6, 1996 |                          |                                |  | 3. Time of Death<br>7:00 P.M.    |  |   |   |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>Frederick Health Care Center |   |  |   | 4b. City, Town, or Location of Death<br>Frederick   |                          |                                |  | 4c. County of Death<br>Frederick |  |   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-18-8954   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>90 Yrs.           |                          | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 1, 1906 |   | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|  | Usual Residence of Decedent  |   |  |   |   |                          |                                |  |                                  |  |   |   |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Frederick  |   |                          |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                  |  |   |   |  |  |
| 10e. Street and Number<br>1421 Taney Ave.  |  |   |  | 10f. Zip Code<br>21702  |   |                          |                                | 10g. Citizen of What Country?<br>United States   |                                  |  |   |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |                          |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |                                  |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>8th -   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerical   |   |                          |                                | 16b. Kind of Business/Industry<br>Printing Company   |                                  |  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>John W. King  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie A.  |   |                          |                                |  |                                  |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert L. Mauck ( son )  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24317 Preakness Dr./ Damascus, Maryland 20872  |   |                          |                                |  |                                  |  |   |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Linden Hills Cemetery   |   |                          |                                | Date<br>4/10/96  |                                  | 20c. Location - City or Town, State<br>Frederick, Maryland   |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert L. Mauck</i>  |  |   |  | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702   |   |                          |                                |  |                                  |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Atherosclerotic cardiovascular disease</i><br>Due to (or as a consequence of): <i>hypertension, alcohol</i><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |   |                          |                                |  |                                  |  |   | Approximate interval Between Onset and Death<br>7-10 yrs  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>(Organic Brain Syndrome - Dementia)</i>   |  |   |  |   |   |                          |                                |  |                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |  |
|  |  |   |  |   |   |                          |                                |  |                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                          |                                |  |                                  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br>M |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |                                  | 28d. Describe how injury occurred  |   |   |  |  |
|  |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                          |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                     |                                  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |                          |                                |  |                                  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Arthur S. Manalo, M.D.</i>   |  |   |  | 29c. License number<br>P15191   |   |                          |                                | 29d. Date signed (Month, Day, Year)<br>April 5, 1996   |                                  |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Arthur Manalo, M.D. 187 Thomas Johnson Drive Frederick, MD 21702   |  |   |  |   |   |                          |                                |  |                                  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 08 1996   |  |   |  | 32. Registrar's Signature<br><i>John A. Raskell</i>   |   |                          |                                |  |                                  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

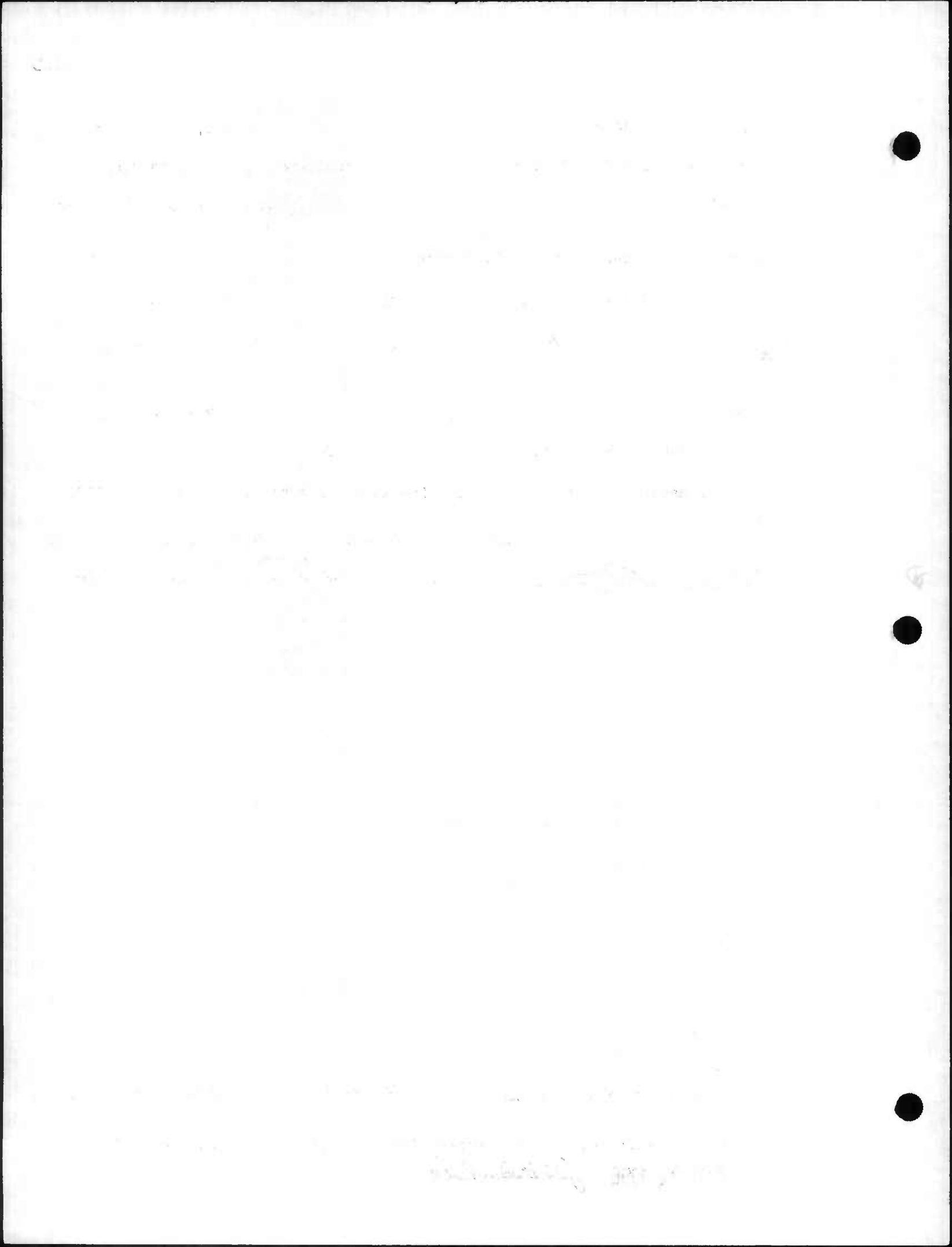
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



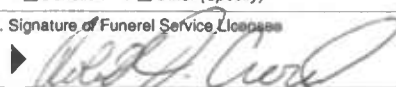
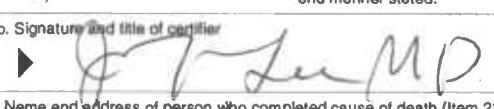
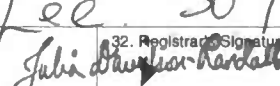
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12360

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |   |
|--|--|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Arvel Bertrand Musick</b>                           |   |  |   | 2. Date of Death<br>Month <b>April</b> , Day <b>11</b> , Year <b>1996</b> |  | 3. Time of Death<br><b>0442</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>             |  | 4c. County of Death<br><b>Harford</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>414 - 32 - 8265</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>                          | 8. Date of Birth (Month, Day, Year)<br><b>March 5, 1927</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>   |
|  | Usual Residence of Decedent  |   |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Perryville</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>141 Jackson Station Road</b>  |  |   |  | 10f. Zip Code<br><b>21903</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chief Electrician</b>   |   | 16b. Kind of Business/Industry<br><b>Automobile Manufacturing</b>                              |   |
| 17. Father's Name (First, Middle, Last)<br><b>Marshall Musick</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mallie Couch</b>  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John A. Musick</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>141 Jackson Station Road, Perryville, MD 21903</b>  |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Bridge Baptist Cem.</b>  |   | 20c. Location - City or Town, State<br><b>4/15/96 Rising Sun, Maryland</b>                     |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Crouch Funeral Home</b><br><b>127 South Main Street, North East, MD 21901</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac arrest</b><br><br>Due to (or as a consequence of):<br><b>Coronary artery disease</b><br><br>Due to (or as a consequence of):<br><b>Chronic obstructive lung disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |   |  |   |   |  | Approximate Interval Between Onset and Death  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |
|  |  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |
|  |  |   |  | 28e. Place of Injury - At home, term, street, lecture, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |  |   |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D20661</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/11/96</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Lee 307 S. Union Ave Havre de Grace MD</b>   |  |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>  |  |   |  | 32. Registrar's Signature<br>  |   |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12361

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>J C Main   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 13, 1996   |  | 3. Time of Death<br>0908  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>201 Hollingsworth Manor  |  |  |  | 4b. City, Town, or Location of Death<br>Elkton   |  | 4c. County of Death<br>Cecil  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>230-14-0468   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>78 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 20, 1918  |  |
|   | 9. Birthplace (State or Foreign Country)<br>North Carolina   |  | 10a. State<br>Maryland   |  | 10b. County<br>Cecil   |  | 10c. City, Town or Location<br>Elkton   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>201 Hollingsworth Manor  |  | 10f. Zip Code<br>21921   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Groundskeeper   |  | 16b. Kind of Business/Industry<br>University of Delaware   |  | 17. Father's Name (First, Middle, Last)<br>Moses A. Main  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bessie Osbourne   |  | 19a. Intomment's Name/Relationship (Type, Print)<br>Pauline M. Main  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>201 Hollingsworth Manor - Elkton, MD 21921  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gilpin Manor Memorial Park   |  | 20c. Location - City or Town, State<br>Elkton, Maryland  |  | 21. Signature of Funeral Service Licensee<br>Dorcas S. Hicks   |  | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, MD 21921-5521   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Coronary Artery Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Diabetes Mellitus, Hypertension |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
|   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Monte Makous, MD  |  | 29c. License number<br>D-44783   |  | 29d. Date signed (Month, Day, Year)<br>April 15, 1996   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>111 W. HIGH ST. ELKTON, MD 21921   |  | 31. Date filed (Month, Day, Year)<br>APR 16 1996   |  | 32. Registrar's Signature<br>Julia [Signature]   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 12362

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eva M. McKenzie  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 2 1996   |  |  |  | 3. TIME OF DEATH<br>7:20 P M  |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213 24 5234   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>93 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>NOV 14, 1902 |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FROSTBURG VILLAGE NURSING HOME   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FROSTBURG   |  |   |  | 9c. COUNTY OF DEATH<br>ALLEGANY                     |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>ALLEGANY  |  | 10c. CITY, TOWN OR LOCATION<br>FROSTBURG   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>155 S. WATER STREET  |  |  |  |  |  | 10f. ZIP CODE<br>21532   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.               |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>FRANK GUNNETT   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>NETTIE MYERS  |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>FRANCES BENNY  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>205 GLENWOOD TRAIL, GOLDSBORO, NC 27534 |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>FROSTBURG MEMORIAL PARK, 4/5/96   |  |  |  | 20c. LOCATION — City or Town, State<br>FROSTBURG, MD 21532  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Minibou M. Sowers</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SOWERS FUNERAL HOME, P.A.<br>60 W. MAIN ST., FROSTBURG, MD 21532   |  |  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  |   |  |   |  | 2 days  |  |  |  |
| a. UREMIA<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |   |  | 5 years   |  |  |  |
| b. RENAL FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| c. END stage Hypertensive Renal Disease unknown<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| d.   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Severe Degenerative ARTHRITIS<br>HYPERTENSION  |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                   |  |   |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Chang</i>   |  |  |  |  |  | 29c. LICENSE NUMBER<br>D25638  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 4, 1996  |  |   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SATURNINA CHANG, M.D. RT 36 FROSTBURG PLAZA FROSTBURG, Maryland 21532   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 15 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John B. ...</i>  |  |  |  |   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12363

## Certificate of Death

Reg. No.

|  |   |  |   |   |   |  |  |  |
|--|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Norma Kathryn McGOWAN   |  |   |   | 2. Date of Death<br>Month Day Year<br>APRIL 15 1996   |  | 3. Time of Death<br>5:05   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Hagerstown  |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>219-20-1447  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>71 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 15, 1924  |  |
|  | 10a. State<br>Maryland  |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Hagerstown   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by<br>Funeral Director           | 10e. Street and Number<br>910 Guilford Avenue   |  |   |   | 10f. Zip Code<br>21740  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>mechanic                                  |   | 16b. Kind of Business/Industry<br>aircraft  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Jacob Franklin House   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel Geneva Snyder  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Larry McGowan   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>542 N. Mulberry St., Hagerstown, Md. 21740   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery  |   | Date<br>4-19-96   |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnick</i>  |  |   |   | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>terminal lung obstructive pulmonary disease 2 days</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. {<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |  |  |
| State<br>Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |  |
|  | 29b. Signature and title of certifier<br><i>Dr. [Signature]</i>   |  |   |   | 29c. License number<br>208041   |  | 29d. Date signed (Month, Day, Year)<br>4-16-96   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>E. R. [Signature] 382 [Signature] Hagerstown, Md 21740  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 17 1996 |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12364

## Certificate of Death

Reg. No.

|  |   |  |   |                                |   |
|--|---|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Geraldine Marie Murray</i>   |  | 2. Date of Death<br>Month <i>April</i> Day <i>12</i> Year <i>96</i>   |                                | 3. Time of Death<br><i>4:55 PM</i>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Washington Co. Hospital</i>  |  | 4b. City, Town, or Location of Death<br><i>Hagerstown, MD</i>   |                                | 4c. County of Death<br><i>Washington</i>  |
| Funeral<br>Director  | 5. Social Security Number<br><i>163-40-5772</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>75</i> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hour Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><i>May 5, 1920</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>Penna.</i>   |                                |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |  |   |                                |   |
|  | 10a. State<br><i>Penna.</i>   | 10b. County<br><i>Franklin</i>   | 10c. City, Town or Location<br><i>Greencastle</i>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | 10e. Street and Number<br><i>235 S. Ridge Ave.</i>  |  | 10f. Zip Code<br><i>17225</i>   |                                | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)                      |                                |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>   |  | 16b. Kind of Business/Industry<br><i>Home</i>   |                                |   |
|  | 17. Father's Name (First, Middle, Last)<br><i>Charles Samuel Madara</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Violet Marie Beegle</i>   |                                |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Sharon Baumbaugh</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>789 Eastside Dr. Greencastle, Pa. 17225</i>   |                                |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Cedar Hill Cemetery</i>  |                                | 20c. Location - City or Town, State<br><i>Greencastle, Pa.</i>  |
|  | 21. Signature of Funeral Service Licensee<br><i>H. Martin Zimmerman</i>   |  | 22. Name and Address of Facility<br><i>Zimmerman And Son Funeral Home<br/>Greencastle, Pa. 17225</i>  |                                |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Metastatic Endometrial Cancer</i><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b.</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i> |  |   |                                | Approximate Interval Between Onset and Death<br><i>2 1/2 years</i>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of injury<br><i>M</i>   |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |   |
|  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |   |
| State Registrar  | 29b. Signature and title of certifier<br><i>Michael J. McCormack M.D.</i>   |  | 29c. License number<br><i>041667</i>  |                                | 29d. Date signed (Month, Day, Year)<br><i>4.12.96</i>   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Michael J. McCormack 1799 Howell Road Hagerstown, MD 21740</i>   |  |   |                                |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1996</b>              |   | 32. Registrar's Signature<br><i>John Anderson-Randall</i>                  |   |                                |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 12365

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Herbert D. Morris, Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 8, 1996</b>  |  | 3. TIME OF DEATH<br><b>2210 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-05-2246</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 15, 1919</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Delaware</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>104 Hollywood Beach Road</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chesapeake City</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Chesapeake City</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>104 Hollywood Beach Road</b>  |  |
| 10f. ZIP CODE<br><b>21915</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Heavy Equipment Operator</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herbert D. Morris, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret E. Magulgan</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Phyllis M. Parris</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1485 Bering Drive - Houston, TX 77057</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gracelawn Memorial Park 4/8/96</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>New Castle, Delaware</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. Hicks</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, MD 21921-5521</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER, BRAIN</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY M   |  |  |  |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Phyllis M. Parris</i>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D07463</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-9-96</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Rolando A. Najera, M.D. - 118 North Street - Elkton, MD 21921</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 10 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





## Certificate of Death

Reg. No

|   |  |  |   |   |   |   |   |   |  |  |  |  |
|---|--|--|---|---|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Pauly McFarland</b>  |  |   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>April 5, 1996</b>  |   | 3. Time of Death<br><b>9:50 P.M.</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |   |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>    |   | 4c. County of Death<br><b>Frederick</b>  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>041-20-7613</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>June 21, 1928</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>                                 |  |  |  |
|   | Usual Residence of Decedent  |  |   |   |   |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Ijamsville</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>3408 Mockingbird Court</b>  |  |   |   | 10f. Zip Code<br><b>21754</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |   |  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>6</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Senior Engineer</b>   |   |   | 16b. Kind of Business/Industry<br><b>I.B.M.</b>                         |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Raymond J. McFarland</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Pauly</b>  |   |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Jayne Gay McFarland, Wife</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3408 Mockingbird Court, Ijamsville, MD 21754</b>  |   |   |   |  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory, April 6, 1996</b>              |   |   | Date<br><b>Smithsburg Crematory</b>                         |   | 20c. Location - City or Town, State  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Allan H Ruby MO0703</b>  |  |   | 22. Name and Address of Facility<br><b>Keeney &amp; Basford P.A. Funeral Home<br/>106 East Church Street, Frederick, MD 21701</b> |   |   |   |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>{</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Emphysema</b> |  |   |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>Years</b> |  |
|   | Physician<br>/Medical<br>Examiner  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |   |   |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred                                       |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |   |   |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |   |   |   |   |  |  |  |  |
|   | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |   |   | 29c. License number<br><b>D 22101</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>4/6/96</b>   |  |  |  |
|   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Lloyd A. Hunsicker MD 1475 Tanager Ave. Frederick Md</b>  |  |   |   |   |   |   |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 09 1996</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |   |   |   |  |  |  |  |

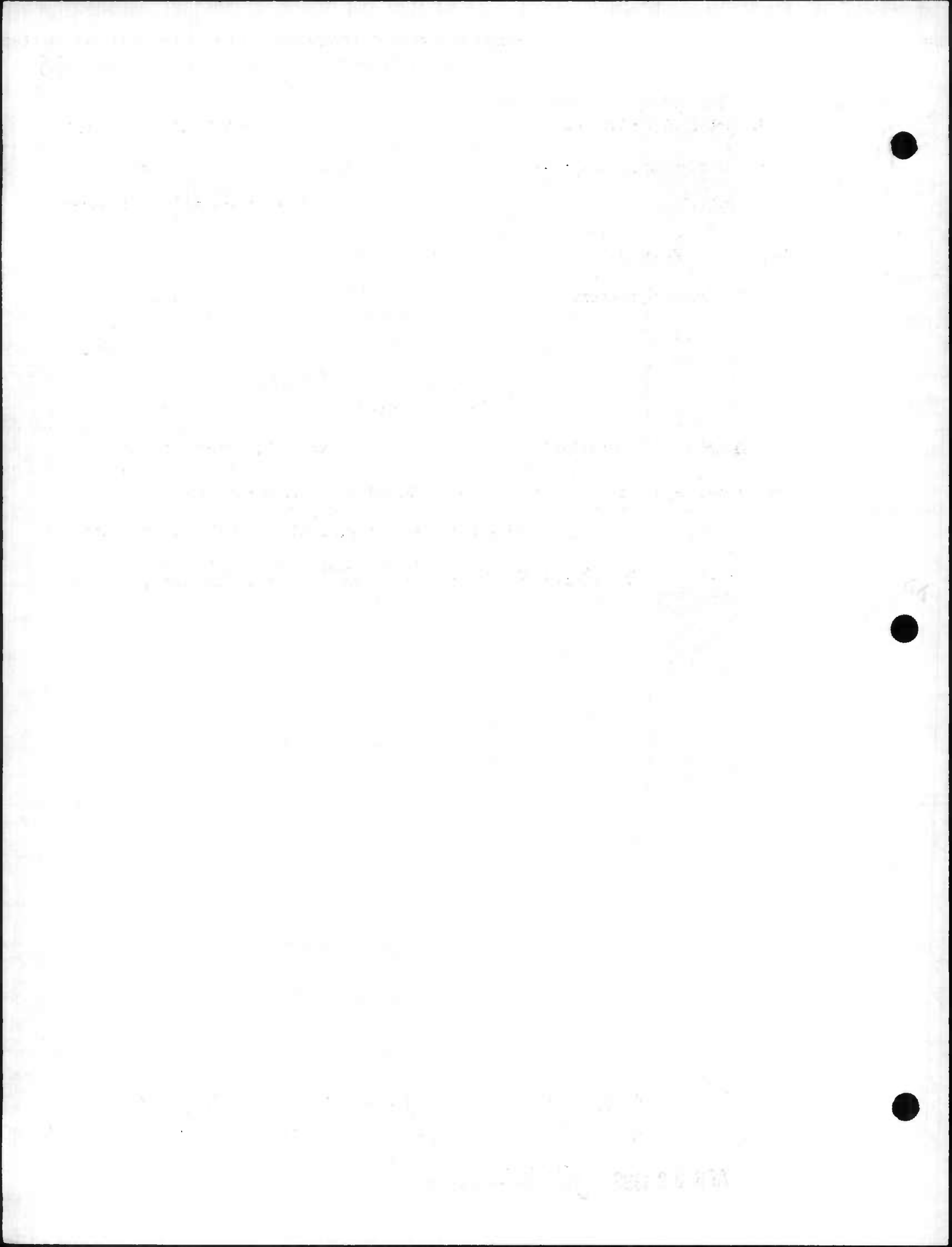
**Division of Vital Records, P.O. Box 68760,**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**




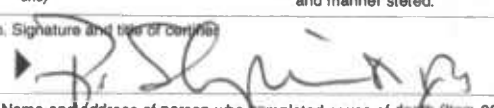
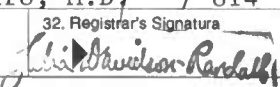
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12367

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |   |  |  |
|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DWIGHT ELDON MOSS                                 |  |  |  | 2. Date of Death<br>Month Day Year<br>March 30, 1996 |   | 3. Time of Death<br>4:30 PM.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital |  |  |  | 4b. City, Town, or Location of Death<br>Frederick    |   | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director   | 5. Social Security Number<br>274-32-2801  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>62 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>Feb. 14, 1934   |  |
|   | 10a. State<br>Maryland  |  | 10b. County<br>Frederick   |  | 10c. City, Town or Location<br>Jefferson             |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br>3889 Shadywood Dr.  |   | 10f. Zip Code<br>21755   |  | 10g. Citizen of What Country?<br>United States   |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                            |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Millwright  |  | 16b. Kind of Business/Industry<br>Aluminum Manufacturer  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Moss   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alice Chester   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Donna R. Stumbo Moss (wife)   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3889 Shadywood Dr. / Jefferson, Maryland 21755  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Memorial   |  | 20c. Location - City or Town, State<br>4-3-96 Frederick, Maryland  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br>Stauffer Funeral Home<br>1621 Opossumtown Pike/Frederick, Md. 21702  |  |   |  |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Acute Myocardial Infarction</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Aortic Stenosis (Rheumatic Heart Disease)</u>  |   |  |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D 07186   |  | 29d. Date signed (Month, Day, Year)<br>4/1/96   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Philip Shapiro, M.D. / 814 Toll House Ave. / Frederick, Maryland 21701  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 04 1996  |   | 32. Registrar's Signature<br>   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

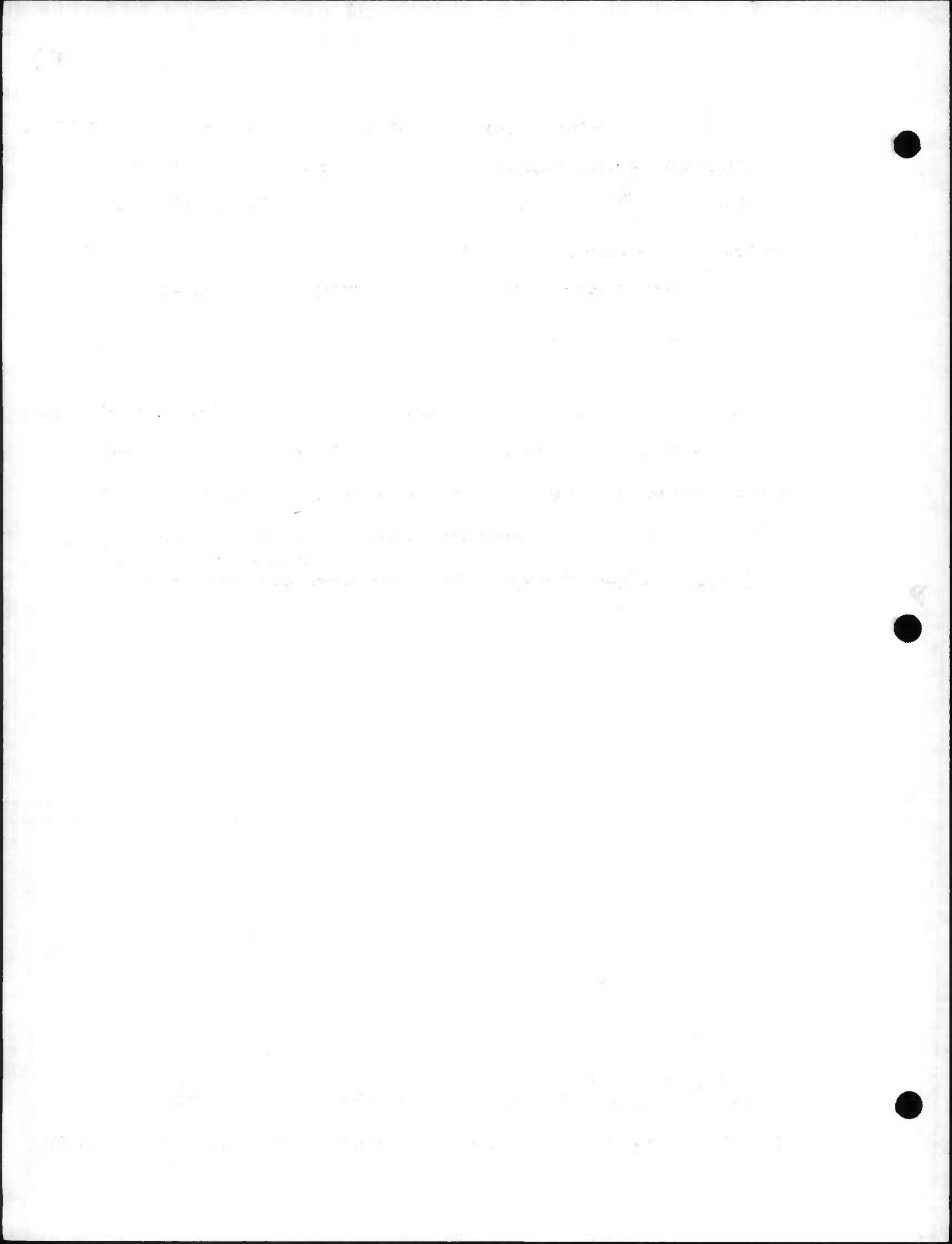
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12368

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edna Mae Moxley</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>25</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>7:23 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-84-9453</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 28, 1917</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Health Care Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Mt. Airy</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>13910 Penn Shop Rd.</b>   |  |
| 10f. ZIP CODE<br><b>21771</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Housewife</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William E. Buxton</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgia Ella Purdum</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy G. Sprague</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27408 Ridge Rd., Damascus, Md. 20872</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Providence Methodist 3/28/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Kemptown, Md.</b>  |  |
| 21. SIGNATURE OF FURNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiovascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Due to (OR AS A CONSEQUENCE OF):</b><br>d. <b>Due to (OR AS A CONSEQUENCE OF):</b><br>Approximate Interval Between Onset and Death<br><b>~ 5 yrs.</b><br><b>&gt; 10 yrs.</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arthur C. Manalo</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>0-18191</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 26, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arthur C. Manalo, M.D. 11801 Fingerboard Rd., Monrovia, Md. 21770</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 29 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Arthur C. Manalo</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12369

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>James William Miller, Sr.   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 24, 1996                        |  | 3. Time of Death<br>3:50 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |  |   |  | 4b. City, Town, or Location of Death<br>Frederick                           |  | 4c. County of Death<br>Frederick   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-34-0068  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>60 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>January 16, 1936                     |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Frederick  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>4204 Lime Kiln Road   |  |   |  | 10f. Zip Code<br>21703  |  | 10g. Citizen of What Country?<br>United States                              |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 54 - 58 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Shipping/ Receiving Foreman                  |  |   |  | 16b. Kind of Business/Industry<br>U.S. Government-NBS                       |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Norman Elmer Miller  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Adela Margarete Rinehart |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Bonnie Kay Miller/ Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4204 Lime Kiln Rd, Frederick, MD 21703   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens 3/28   |  | 20c. Location - City or Town, State<br>Frederick, Maryland                  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>T. B. Mackey   |  |   |  | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>1621 Opossumtown Pike, Frederick, MD 21702  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. End stage Liver Disease<br>Due to (or as a consequence of):<br>b. Alcoholic Cirrhosis<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Esophageal varices<br>G-B. bleed,<br>Encephalopathy   |  |   |  |   |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br>27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide<br>28a. Date of injury (Month, Day Year)<br>28b. Time of injury<br>M<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>J. H. S. M.D.  |  | 29c. License number<br>D 34303  |  | 29d. Date signed (Month, Day, Year)<br>March 25-96  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e), (Type, Print)<br>IRFAN W. HASSEN M.D. 501 TOLL HOUSE AVE, FREDERICK   |  |   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 27 1996  |  | 32. Registrar's Signature<br>John A. H. R. R.   |  |   |  |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12370

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Thomas Francis McCormack   |  |  |  | 2. Date of Death<br>Month Day Year<br>March 23, 1996  |  | 3. Time of Death<br>2:40 PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Frederick   |  | 4c. County of Death<br>Frederick  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>110-07-7756   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>77 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 14, 1918  |  |
|  | 9. Birthplace (State or Foreign Country)<br>New York   |  | 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Frederick  |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>815-F Stratford Drive  |  | 10f. Zip Code<br>21701  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Oct 1940 July, 1964  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Chief Inspector  |  | 16b. Kind of Business/Industry<br>A.S.P.C.A.  |  | 17. Father's Name (First, Middle, Last)<br>Thomas Francis McCormack SR  |  |
|  | 17. Mother's Name (First, Middle, Maiden Surname)<br>Marion Wilkes   |  | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Chief Inspector  |  | 18b. Kind of Business/Industry<br>A.S.P.C.A.  |  | 19. Intomment's Name/Relationship (Type, Print)<br>Lena McCormack, Wife   |  |
| To Be Completed by<br>Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>815-F Stratford Drive, Frederick, MD 21701  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Crematory, Mar. 25, 1996   |  | 20c. Location - City or Town, State<br>Smithsburg, Maryland   |  |
|  | 21. Signature of Funeral Service Licensee<br>Allan H Ruby MO0703   |  | 22. Name and Address of Facility<br>Keeney & Basford P.A. Funeral Home<br>106 East Church Street, Frederick, MD 21701  |  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Intracerebral hemorrhage<br>Due to (or as a consequence of):<br>b. N/A<br>Due to (or as a consequence of):<br>c. N/A<br>Due to (or as a consequence of):<br>d. N/A<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>11 days   |  |
| To Be Completed by<br>Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
| To Be Completed by<br>Physician/Medical Examiner | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>M. Raphaelson MD   |  | 29c. License number<br>D 26660  |  |
|  | 29d. Date signed (Month, Day, Year)<br>3/23/96   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>M. Raphaelson MD 801 Toll House Ave #H-6 Frederick MD  |  | 31. Date filed (Month, Day, Year)<br>MAR 25 1996  |  | 32. Registrar's Signature<br>J. Davidson-Randall  |  |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12371

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lena Alice Martin</b>   |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>5</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>3:45 A.M.</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Larkin-Chase Nursing Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Bowie</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>325-20-5340</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 6. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 17, 1899</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Texas</b>   |  |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>13211 Ovalstone Lane</b>  |   |   |  | 10f. Zip Code<br><b>20715</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>No</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>No</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) not available</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Textile Worker</b>                       |  | 16b. Kind of Business/Industry<br><b>Fabric</b>  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward Martin</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Moore</b>   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vera Mae Harris</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10.</b>  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Cemetery</b>   |  | Data<br><b>April 10 1996</b>   |  | 20c. Location - City or Town, State<br><b>Chicago, Illinois</b>                                |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert E. Evans Pres</b>   |   |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>AZOTEMIA</b><br>Due to (or as a consequence of):<br><b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>Advance Alzheimers disease</b><br>Due to (or as a consequence of):<br><b>1</b> |   |   |  |  |  |  |  |  |
|  | Approximate Interval Between Onset and Death<br><b>3/8/96</b><br><b>3/8/96</b><br><b>several yrs.</b>  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multiple Decubitus ulcers</b><br><b>Urinary tract Infection</b>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ka Kesh Arora, MD</b>   |   | 29c. License number<br><b>D20108</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>4/15/96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAKESH ARORA, MD 14300 GALLANT FOX LN #222 BOWIE MD 20715</b> |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>  |  | Registrar's Signature<br><b>J. P. Anderson</b>  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12372

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |  |  |  |   |  |
|--|---|--|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Edith Moten   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 7, 1996   |  | 3. Time of Death<br>10:55 A.M.   |  |  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Largo  |  |   |  | 4b. City, Town, or Location of Death<br>Largo, MD   |  | 4c. County of Death<br>Prince Georges  |  |  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-60-5306  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>93 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 7, 1902                                  |  | 9. Birthplace (State or Foreign Country)<br>Wash., DC  |  |   |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD  |  | 10b. County<br>Prince Georges   |  | 10c. City, Town or Location<br>Fort Washington  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>12100 Asbury Drive  |  |   |  | 10f. Zip Code<br>20744  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk |   |  | 16b. Kind of Business/Industry<br>U.S. Treasury Dept.                                |  |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>George Addison   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>unknown  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>George McNeal   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12100 Asbury Drive, Ft. Washington, MD 20744   |  |  |  |  |  |   |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Memorial Cemetery 4-12  |  | Date<br>Suitland, MD   |  | 20c. Location - City or Town, State  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>J. P. Marshall   |  |   |  | 22. Name and Address of Facility<br>Marshall's Funeral Home, Inc.<br>4217 9th St. N.W., Wash., DC 20011   |  |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Atherosclerotic Cardiovascular Disease 10 years.<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |  |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>sepsis, congestive heart failure<br>Dementia  |  |   |  |   |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
|  | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br>[Signature]  |  |  |  | 29c. License number<br>D34274  |  | 29d. Date signed (Month, Day, Year)<br>4-7-96 |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sam Tellawi, M.D., P.A. 4000 Mitchellville Road, Suite A-112, Bowie, MD 20716   |  |   |  |   |  |  |  |  |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>APR 12 1996  |  |   |  | 32. Registrar's Signature<br>John Anderson-Randall  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12373

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |  |  |   |   |  |
|---|---|--|--|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH F. MILLS, SR.</b>                                 |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 8 1996</b>  |  | 3. Time of Death<br><b>11:23 A</b>   |  |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Columbia, MD</b>  |  | 4c. County of Death<br><b>Howard County</b>  |  |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-32-6487</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov 25 1910</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>McLeon, VA</b> |   |  |
|   | Usual Residence of Decedent   |  |  |   |  |  |  |  |   |   |  |
| 10a. State<br><b>Maryland</b>   |   |  | 10b. County<br><b>Howard County</b>  |   | 10c. City, Town or Location<br><b>Columbia, Maryland</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
| 10e. Street and Number<br><b>7059 Longview Road</b>   |   |  |  | 10f. Zip Code<br><b>21044</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Servant</b> |  |  | 16b. Kind of Business/Industry<br><b>Federal Government<br/>Dept. of the Army</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Henry Mills</b>  |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evangeline Watts</b>   |  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Johnson/Daughter</b>  |   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7059 Longview Road Columbia, Maryland 21044</b>  |  |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial</b>  |   |  | Date<br><b>4/13</b>  |  | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>                               |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  |   | 22. Name and Address of Facility<br><b>Alexander S. Pope Funeral Homes<br/>5538 Marlboro Pike Forestville, MD. 20747</b>   |  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Atherosclerotic cardiovascular disease/Hypertension</u> years<br>Due to (or as a consequence of):<br><br>b. <u>Motor-neuron disease</u> 3 years<br>Due to (or as a consequence of):<br><br>c. <u>Cachexia secondary to motor-neuron disease</u> 3 years<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |   |  |  |  |  |   | Approximate interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>Depression</u><br><br><u>Blindness</u>   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                             |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  | 29b. Signature and title of certifier<br> |  | 29c. License number<br><b>D25210</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/10/96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jerry E. Seals, MD, 3460 Ellicott Center Drive, Ellicott City, MD 21043</b>  |   |  |  |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>   |   |  |  |   | 32. Registrar's Signature<br>   |  |  |  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100/10  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.State  
Registrar





96 12374

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>RUTH MACK</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 3, 1996</i>   |  | 3. TIME OF DEATH<br><i>7:12 PM</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>579-52-5458</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>78</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Nov 8, 1917</i>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Wash., D.C.</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>SOUTHEAST HAYWARD HOSPITAL</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CLINTON</i>  |   |
| 9c. COUNTY OF DEATH<br><i>PRINCE GEORGES</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Prince Georges</i>   |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Clinton</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>9211 Stuart Lane</i>  |   |
| 10f. ZIP CODE<br><i>20735</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Laundry Worker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Private</i>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>GEORGE THOMAS</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>KATHERINE EDELIN</i>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>CHARLES HARVEY (Nephew)</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2608 Fairlawn Street, Temple Hills, Md 20748</i>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mt. Olivet Cemetery 4/12</i>   |  | 20c. LOCATION — City or Town, State<br><i>WASHINGTON, D.C.</i>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>May S. Pope</i> M859   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 Marlboro Pike, Forestville, Md 20747</i>   |  |  |   |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Rt Mid Zone Pneumonia</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Septic</i><br><i>Actual fibrillation</i><br><i>Organic brain syndrome</i> |  |  |  |  |  |  | Approximate interval Between Onset and Death<br><i>10h</i><br><i>10h</i><br><i>1hr</i>                    |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></i>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>MD Attending</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D-24535</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/4/96</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Lt. James Beane 7700 OLD ISHACHT AVE. CLINTON MD 20735</i>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 09 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johi...</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12375

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |  |  |  |  |  |
|--|--|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY VIRGINIA OSTER</b>  |   |   |   | 2. Date of Death<br>Month Day Year<br><b>April 13, 1996</b>   |  |  |  | 3. Time of Death<br><b>2:00 P</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  |  |  | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-66-0470</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 26 1913</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>W. VA.</b>  |  |
|  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>ALLEGANY</b>  |   | 10c. City, Town or Location<br><b>CUMBERLAND</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>516 SCHLUND AVE.</b>  |   |   |   | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSE KEEPER</b>                  |   | 16b. Kind of Business/Industry<br><b>HOUSE KEEPER</b>   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>EDGAR HOLLAND BENDER</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LENA AMY BROWN</b>  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLES V. OSTER SON</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7914 JUNIPER DRIVE FREDERICK, MARYLAND 21702-2808</b>   |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SUNSET MAUSOLEUM</b>   |   | 20c. Location - City or Town, State<br><b>APRIL 16 1996 CUMBERLAND MARYLAND</b>   |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br><b>MERRITT-ADAMS FUNERAL HOME<br/>404 DECATUR STREET CUMBERLAND MARYLAND 21502</b>  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   | 23b. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Left Lower Lobe pneumonia with Pleural Effusion</b><br>Due to (or as a consequence of):<br>b. <b>Carcinoma of Breast</b><br>Due to (or as a consequence of):<br>c. <b>Massive Hemangioma</b><br>Due to (or as a consequence of):<br>d. |  |  |  | Approximate Interval Between Onset and Death<br><b>3 Weeks</b><br><b>July 1995</b><br><b>Since Birth</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA     |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br> MD |   | 29c. License number<br><b>D 23371</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 15, 1996</b>                     |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Q. Zaman Johnson Heights Medical Bldg. Cumberland, MD 21502</b>   |  |   |   | 31. Date filed (Month, Day, Year)<br><b>APR 16 1996</b>   |   |  |  | 32. Registrar's Signature<br> |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Washburn & Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12376

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sallie Perry

2. Date of Death

Month  
Apr

Day

15

Year

1996

3. Time of Death

3:30 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

56 Ayers Dr.

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

239-34-8460

8. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 9, 1907

9. Birthplace (State or Foreign Country)

Ashe Co., NC

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Colora

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

146 Barnes Corner Rd.

10f. Zip Code

21917

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Sewing Factory

17. Father's Name (First, Middle, Last)

Albert Shaw

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Jones

19a. Informant's Name/Relationship (Type, Print)

Edna Hayden

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

56 Ayers Dr., Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ebenezer Cemetery

Date

4/17/96 Rising Sun, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R.T. Foard Funeral Home

21911

111 S. Queen St., P.O. Box 248 Rising Sun, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CHRONIC CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ISCHEMIC CARDIO MYO PATHY

Due to (or as a consequence of):

c. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 07463

29d. Date signed (Month, Day, Year)

4-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rolando A. Najera, M.D.

31. Date filed (Month, Day, Year)

APR 18 1996

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1944

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE HOUSE OF COMMONS

IN RESPONSE TO A RESOLUTION PASSED BY THE HOUSE OF COMMONS

ON 11th JANUARY 1944

BY THE HON. THE MEMBER FOR ...

IN CONNECTION WITH THE ...

LAND ...

AND ...

IN THE ...

OF THE ...

AND ...

...

APR 1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12377

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Bessie L. Price</b>                                 |   |  |   | 2. Date of Death<br>Month <b>4</b> Day <b>6</b> Year <b>96</b> |   | 3. Time of Death<br><b>18 : 05</b>                      |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Laurelwood Nursing Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>          |   | 4c. County of Death<br><b>Cecil</b>                     |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-58-3001</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>7-28-1899</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>York, Pa.</b>                                       |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Cecil</b>                                    |   | 10c. City, Town or Location<br><b>Elkton</b>            |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>150 E. Main St</b>   |  | 10f. Zip Code<br><b>21921</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>No</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>George Brown</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>No Record</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Samuel J. Price - son</b>  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>150 E. Main St, Elkton, Md. 21921</b>                                      |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hickory Grove Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Port Penn, Del.</b>   |   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |
| 22. Name and Address of Facility<br><b>Daniels &amp; Hutchison</b><br><b>212 N. Broad St, Middletown, De. 19709</b>  |  | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Acute myocardial Infection</b><br>Due to (or as a consequence of):<br><b>b. old CVA</b><br>Due to (or as a consequence of):<br><b>c. ASVD</b><br>Due to (or as a consequence of):<br><b>d. CHF acute &amp; chronic</b> |  | Approximate Interval Between Onset and Death<br><b>10 min.</b><br><b>1 yr</b><br><b>5 yrs</b><br><b>1 yr</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)  |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 29b. Signature and title of certifier<br><b>Jui-Ch. h HSU MD</b>   |  | 29c. License number<br><b>D0482B</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-6-96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jui-Ch. h HSU MD 223 W. Main St Elkton, MD 21921</b>   |   | 31. Data filed (Month, Day, Year)<br><b>APR 10 1996</b>   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





96 12378

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
|--|---|--|--|---|--|---|--|---|---|---|--|--------------------------------------|-------|---|--------|-----------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES HOBART PATRICK</b>  |   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 5, 1996</b>  |  | 3. TIME OF DEATH<br><b>7:20 p.m.</b>  |  |   |   |   |  |                                      |       |   |        |                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217050603</b>  |   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 5, 1918</b>                                      |  |   |   |   |  |                                      |       |   |        |                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>   |   |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b>   |  |   |   |   |  |                                      |       |   |        |                 |  |
| RESIDENCE OF DECEDENT  |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 10a. STATE<br><b>Maryland</b>  |   | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Westernport</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |   |   |  |                                      |       |   |        |                 |  |
| 10e. STREET AND NUMBER<br><b>326 Maryland Ave.</b>   |   |  |  | 10f. ZIP CODE<br><b>21562</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |   |   |   |  |                                      |       |   |        |                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Maintenance Dept. Westvaco Paper Manufacture</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hobart Patrick</b>   |   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Cullen</b>   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn Wilson</b>   |   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>326 Maryland Ave. Westernport, Md. 21562</b>  |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Philos Cemetery 4-9-96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Westernport, Md.</b>  |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wayne C. Spiggle</i>   |   |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Boal Funeral Home<br/>111 Church St. Westernport, Md.</b>  |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| <table border="0"> <tr> <td rowspan="4">{</td> <td>a. <b>Advanced Congestive Heart Failure</b></td> <td rowspan="4">{</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <b>Adenocarcinoma of the Lung</b></td> <td>6 yrs</td> </tr> <tr> <td>c. <b>Arteriosclerotic Cardiovascular Disease</b></td> <td>16 yrs</td> </tr> <tr> <td>d. <b>Other</b></td> <td></td> </tr> </table>                  |   |  |  |   |  |   |  | { | a. <b>Advanced Congestive Heart Failure</b> | { | Approximate Interval Between Onset and Death | b. <b>Adenocarcinoma of the Lung</b> | 6 yrs | c. <b>Arteriosclerotic Cardiovascular Disease</b> | 16 yrs | d. <b>Other</b> |  |
| {  | a. <b>Advanced Congestive Heart Failure</b>       | {  | Approximate Interval Between Onset and Death |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
|  | b. <b>Adenocarcinoma of the Lung</b>              |  | 6 yrs  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
|  | c. <b>Arteriosclerotic Cardiovascular Disease</b> |  | 16 yrs                                       |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
|  | d. <b>Other</b>                                   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |   |   |   |  |                                      |       |   |        |                 |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |   |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wayne C. Spiggle M.D.</i>  |   |  |  | 29c. LICENSE NUMBER<br><b>D 7135</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-6-96</b>  |  |   |   |   |  |                                      |       |   |        |                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wayne C. Spiggle 912 Seton Dr. Cumberland, Md. 21502</b>   |   |  |  |   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 10 1996</b>  |   |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>   |  |   |  |   |   |   |  |                                      |       |   |        |                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12379

Amended # 9c, 16a; 4/15/96, N.D.S., Allegany County  
 1 - FOR STATE REGISTRAR  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>XXXXXXXXXX</del> <del>XXXXXXXXXX</del> Mariano NMN Piraino   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>04 04 1996  |  | 3. TIME OF DEATH<br>2:15 AM   |  |
| 4. SOCIAL SECURITY NUMBER<br>052-09-0796  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>01/01/14   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Palermo, Sicily   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Egle Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Lonaconing   |  |
| 9c. COUNTY OF DEATH<br>Allegany   |  |   |  | 10a. STATE<br>WV  |  |   |  |
| 10b. COUNTY<br>Hampshire  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Burlington   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>Rt 1 Box 27   |  |   |  |
| 10f. ZIP CODE<br>26710  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Italian                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cabinetery  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Wood  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Benedetto NMN Piraino  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna NMN DiCarlo   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Violet C. Piraino   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt 1 Box 27, Burlington, WV 26710  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Olivet Cemetery 4/6  |  | 20c. LOCATION — City or Town, State<br>Moorefield, WV   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Fraley Funeral Home<br>PO Box 89 Moorefield, WV 26836   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory Failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Chronic Obstructive Pulmonary Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Congestive Heart Failure</u><br><u>Dementia</u>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>N/A</u><br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br>D07004   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/4/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>L.R. MILES, JR., M.D. 57 JACKSON ST. LONA CONING MD 21539  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 15 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12380

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ROSS PRIBBLE

2. Date of Death

Month Day Year  
4 15 96

3. Time of Death

5:26 PM

4a. Facility Name (If not institution, give street and number)

Washington Co. Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

231 03 9725

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 17, 1921

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

PA

10b. County

Franklin

10c. City, Town or Location

Greencastle

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

2226 Pikeside Drive

10f. Zip Code

17225

10g. Citizen of What Country?

U S

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Postal Clerk

18b. Kind of Business/Industry

U S Postal Service

17. Father's Name (First, Middle, Last)

John Fletcher Pribble

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Lee Arthur

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lorraine F. Pribble

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2226 Pikeside Drive, Greencastle, PA 17225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/19/96

20c. Location - City or Town, State

Greencastle, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich-Miller-May Funeral Home,  
521 S. Washington St., Greencastle, PA 17225

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypoxemia

Due to (or as a consequence of):

8 Hours

c. Urosepsis

Due to (or as a consequence of):

1 Day

d. Parkinsonism

Due to (or as a consequence of):

6 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Rib Fracture 2° Fall 2° Parkinsonism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

5823390

29d. Date signed (Month, Day, Year)

4-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY B. WEBSTER MD 1110 MEDICAL CAMPUS RD HAGERSTOWN MD 21740 suite 107

31. Date filed (Month, Day, Year)

APR 1 8 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 12381

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Marion Pickett</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>28</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>1:55 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-18-6086</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (in yrs. last birthday)<br><b>80</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 27, 1916</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>24724 Woodfield School Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>                               |  |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>24724 Woodfield School Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20882</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                            |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unknown Pickett</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna Mary Pickett</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24724 Woodfield School Rd., Gaithersburg, Md, 20882</b>                                     |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc. 3/30/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Olin L. Molesworth</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pancreatic Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>033686</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 29, 1996</b>                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Krista Miller MD 9715 Medical Center Dr. # 221, Rockville, Md. 20850</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

20

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12382

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last) William Edward Perryman, Jr.  
WILLIAM PERRYMAN2. Date of Death  
Month Day Year  
APRIL 07 1996  
3. Time of Death  
7:45 PMFuneral  
Director4a. Facility Name (If not institution, give street and number)  
Church Home Hospital  
4b. City, Town, or Location of Death  
Baltimore City  
4c. County of Death  
None5. Social Security Number  
578-68-9478  
6. Sex  
1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday)  
44 Yrs.  
8. Date of Birth (Month, Day, Year)  
January 30, 1952  
9. Birthplace (State or Foreign Country)  
Washington, D.C.Usual Residence of Decedent  
10a. State  
Maryland  
10b. County  
None  
10c. City, Town or Location  
Baltimore City  
10d. Inside City Limits  
☒ Yes 2 ☐ No10e. Street and Number  
745 North Patterson Park Avenue  
10f. Zip Code  
21205  
10g. Citizen of What Country?  
United States11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1975-79 1981-85  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc.  
Specify: Black15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
12th grade  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Electrician  
16b. Kind of Business/Industry  
Self-Employed17. Father's Name (First, Middle, Last)  
William Edward Perryman, Sr.  
18. Mother's Name (First, Middle, Maiden Surname)  
Ethel McDrewett Spivey19a. Informant's Name/Relationship (Type, Print)  
Cassandra G. Guillory (sister)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
4730 - 8th Street, N.W.; Washington, D.C. 2001120a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place)  
Quantico National Cemetery  
Date  
April 15, 1996  
20c. Location - City or Town, State  
Quantico, Virginia21. Signature of Funeral Service Licensee  
► [Signature]  
22. Name and Address of Facility  
Latney's Funeral Home, Inc.  
3831 Georgia Avenue, N.W.; Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
immediate Cause (Final disease or condition resulting in death)  
a. CARDIAC ARREST  
Due to (or as a consequence of):  
b. Multiple organ failure  
Due to (or as a consequence of):  
c. Sepsis  
Due to (or as a consequence of):  
d.  
Approximate Interval Between Onset and DeathPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
Gastrointestinal Bleeding  
Hepatic Cirrhosis23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
M  
28c. Injury at Work?  
1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)29a. Certifier (Check only one)  
1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier  
► [Signature] MD  
29c. License number  
D-26594  
29d. Date signed (Month, Day, Year)  
April 7 199630. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
RIAZ BOKHARI M.D. 100 NORTH 13 BROADWAY BALTIMORE MD 2123131. Date filed (Month, Day, Year)  
APR 12 1996  
32. Registrar's Signature  
[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12383

## Certificate of Death

Reg. No.

|  |  |   |   |                               |  |  |  |  |
|--|--|---|---|-------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Parah J. Pope  |   |   |                               | 2. Date of Death<br>Month Day Year<br>April 7, 1996  |  | 3. Time of Death<br>11:55 P.M.                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital  |   |   |                               | 4b. City, Town, or Location of Death<br>Silver Spring, MD  |  | 4c. County of Death<br>Montgomery                                |  |
| Funeral<br>Director  | 5. Social Security Number<br>238-34-2451   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>74 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 5, 1921              |  |
|  | 9. Birthplace (State or Foreign Country)<br>Hamlet, N.C.   |   | 10a. State<br>MD  |                               | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Silver Spring, MD                 |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br>11215 Oakleaf Drive, # 1219   |                               | 10f. Zip Code<br>20901   |  | 10g. Citizen of What Country?<br>USA                             |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4 or 5+)<br>4  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher  |                               | 16b. Kind of Business/Industry<br>Baltimore Public School  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Jesse Johnson   |   |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Parah Irene Williams  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Jacqueline Sands   |   |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2725 Ashmont Terrace, Silver Spring, MD 20906   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Cemetery  |                               | 20c. Location - City or Town, State<br>4-13-96 Suitland, Maryland  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>J. P. Marshall  |   |   |                               | 22. Name and Address of Facility<br>Marshall's Funeral Home, Inc.<br>4217 9th St. N.W., Wash., DC 20011  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Disseminated intravascular coagulation<br>Due to (or as a consequence of):<br>Sepsis<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>12 hrs.<br>16 hrs.  |   |   |                               |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |                               |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                               |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                               |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |                               |  |  |  |  |
| 29b. Signature and title of certifier<br>Lynne V. Perry-Bottinger  |  |   |   | 29c. License number<br>D39797 |  | 29d. Date signed (Month, Day, Year)<br>4/11/96                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lynne V. Perry-Bottinger, M.D. 8401 Colesville RD., #310, Silver Spring, MD 20910  |  |   |   |                               |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 12 1996   |  | 32. Registrar's Signature<br>Judy Anderson-Randall  |   |                               |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12384

Reg. No.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JESSICA PATTERSON</b>                           |  |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>4</b> Year <b>1996</b> |  | 3. Time of Death<br><b>12:06 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MALCOLM GROW HOSPITAL</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Clinton, MD</b>           |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-37-8977</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>3</b> Yrs.  | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>9/12/92</b>  | 9. Birthplace (State or Foreign Country)<br><b>Laurel, MD</b>  |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince Georges</b>   |  | 10c. City, Town or Location<br><b>Severn</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>8383 Flintlock Court</b>   |  |  |  | 10f. Zip Code<br><b>21144</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |  |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas J. Fryer, IV</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Terrie D. Patterson</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas J. Fryer, IV (Father)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>569 Wilson Bridge Drive, Oxon Hill, MD 20746 (#B1)</b>                                   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | Date<br><b>4/10/96</b>   |  | 20c. Location - City or Town, State<br><b>Suitland, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Alex S. Pope, Jr.</b>   |  |  |  | 22. Name and Address of Facility<br><b>Alexander Pope Funeral Homes<br/>5538 Marlboro Pike, Forestville, MD 20747</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HEAD &amp; NECK INJURIES</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4/4/96</b>  |  | 28b. Time of Injury<br><b>1200 Noon</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>PASSENGER OF AUTO VS FIXED OBJECT COLLISION</b>  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5211 TAFT RD, CAMP SPRINGS MD</b>  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Mario F. Golie Jr MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 6, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 12 1996</b>   |  | 32. Registrar's Signature<br><b>J. H. Anderson</b>   |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[illegible]

96 12385

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Blanche Parsons</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 5, 1996</b>   |  | 3. TIME OF DEATH<br><b>5:31P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>410-84-6202</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 7, 1901</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Marshall Town, Iowa</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington Adventist Nursing &amp; Rehab. Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring, Maryland</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>20 Parkside Road</b>  |   |
| 10f. ZIP CODE<br><b>20910</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>   |  |  |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Tennessee State University</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Arnold</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Parker</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ann Shipp</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 Parkside Rd. Silver Spring, MD 20910</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>4-8 Alexandria, VA</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. P. Marshall</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N. W., Washington, DC 20011</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Atrial Fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hypertensive Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Years</b><br><b>Years</b><br><b>Years</b>              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive pulmonary disease</b><br><b>Insulin dependent diabetes mellitus</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Tung P. Lee, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26707</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 8, 1996</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Tung P. Lee, M.D. 700 Buckingham Dr. Silver Spring, MD 20901</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 08 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johi Anderson</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12386

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRIETTA PEAVY

2. Date of Death  
Month Day Year

MARCH 30, 1996

3. Time of Death

2:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

423-20-3393

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-8-1910

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1811 24th ST. N.E. APT. 101

10f. Zip Code

20002

10g. Citizen of What Country?

UNITED STATES AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th GRADE

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LPN

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

JIM PEAVY

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE SISSTRUNK

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA THOMASON DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1811 24th ST. N.E. APT. 101, WASHINGTON, D.C.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY 4-3-96

Date

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON &amp; JENKINS INC.

716 KENNEDY ST. N.W. W.D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute pneumonia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Arteriosclerosis Cardiovascular Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D06674

29d. Date signed (Month, Day, Year)

3/31/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN

2309 SHOREFIELD RD  
WATERLOO MD 20902State  
Registrar

31. Date filed (Month, Day, Year)

APR 11 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

APR 11 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12387

## Certificate of Death

Reg. No.

|   |  |                                   |  |  |  |   |  |  |
|---|--|-----------------------------------|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JANE Markham ROMESBERG</b>  |                                   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>7</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>2:50 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |                                   |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |   | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>225-28-5297-H</b>  |                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 14, 1924</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                               |  |
|   | Usual Residence of Decedent  |                                   |  |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>PENNA.</b>  |                                   | 10b. County<br><b>Bedford</b>  |  | 10c. City, Town or Location<br><b>Hyndman</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>Route 1 Box 13</b>  |                                   |  |  | 10f. Zip Code<br><b>15545</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker-Home</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Markham</b>   |                                   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Cassell</b>  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bruce Romesburg</b>   |                                   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 1 Box 13 Hyndman, Pa. 15545</b>  |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cumberland Crematory</b>  |  | 20c. Date<br><b>4-9-96</b>   |   | 20d. Location - City or Town, State<br><b>Cumberland, Md.</b>                                  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ernest A. Riley</b>  |                                   |  |  | 22. Name and Address of Facility<br><b>Leasure Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Metabolic encephalopathy</b><br>Due to (or as a consequence of):<br>b. <b>Renal failure</b><br>Due to (or as a consequence of):<br>c. <b>Congestive Heart failure</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate interval Between Onset and Death<br><b>4 days</b><br><b>20 days</b><br><b>31 days</b> |                                   |  |  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><br><b>Berlin 7/9/96</b>   |                                   |  |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                   |  |  |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |  |  |  |   |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |  |  |  |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |                                   | 26a. Date of Injury (Month, Day, Year)   |  | 26b. Time of Injury<br><b>M</b>  |   | 26c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred |  |  |  |   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                   |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Jane Markham MD</b>   |  |                                   |  | 29c. License number<br><b>DO 8377</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 8, 1996</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VELENDIA, URIEL, M.D. 924 SETON DRIVE CUMBERLAND, MD. 21502</b>  |  |                                   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1996</b>   |  |                                   |  | 32. Registrar's Signature<br><b>John D. ...</b>  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended # 2, 4/8/96,  
H&S, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12388

Certificate of Death

Reg. No.

|   |   |  |                    |  |  |   |  |  |
|---|---|--|--------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>LARRY ROUTT ROWE  |  |                    |  | 2. Date of Death<br>Month Day Year<br>APRIL 4, 1996    |   | 3. Time of Death<br>07:14 a                          |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |                    |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY |   | 4c. County of Death<br>BALTIMORE                     |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-64-8545  |  | 6. Sex<br>M F<br>M | 7. Age (In yrs. last birthday)<br>41 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>JUNE 15 1954    |   | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |
|   | Usual Residence of Decedent<br>10e. State PA. 10b. County BEDFORD 10c. City, Town or Location CLEARVILLE 10d. Inside City Limits 1 Yes 2 No |  |                    |  | 10f. Zip Code<br>15535                                 |   | 10g. Citizen of What Country?<br>U.S.A.              |  |
| 11. Marital Status<br>1 Never Married 2 Married 3 Widowed 4 Divorced<br>2 Married   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 Yes 2 No<br>2 No  |                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 Yes 2 No<br>2 No  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>OWNER/OPERATOR LONE EAGLE CYCLES CYCLES |                    | 16b. Kind of Business/Industry<br>CYCLES   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>JAMES RICHARD ROWE   |   |  |                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>BETTY PIFER   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>GERI ROWE   |   |  |                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RFD#3 BOX#198 CLEARVILLE, PA. 15535 |  |   |  |  |
| 20a. Method of Disposition<br>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)<br>2 Cremation   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLENDALE CEMETERY APRIL 9 1996   |                    | 20c. Location - City or Town, State<br>FLINTSTONE, MARYLAND  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>Dale L. Merritt  |   | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME<br>404 DECATUR STREET CUMBERLAND MARYLAND   |                    |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Cardiac arrhythmia due to acute renal failure 4 days<br>Due to (or as a consequence of):<br>b. acute renal failure 4 days<br>Due to (or as a consequence of):<br>c. Lymphoma 1 month<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Did tobacco use contribute to the cause of death?<br>1 Yes 2 No 3 Probably 4 Unknown<br>2 No  |                    | 24a. Was an autopsy performed?<br>1 Yes 2 No<br>2 No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 Yes 2 No<br>2 No |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |                    |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 Yes 2 No<br>2 No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)               |                    |  |  |   |  |  |
| 27. Manner of Death<br>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined<br>5 Pending investigation   |   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 Yes 2 No<br>2 No                                      |                    | 28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>Matthew J. Walter M.D.  |                    | 29c. License number<br>N2638   |  | 29d. Date signed (Month, Day, Year)<br>April 4, 1996  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MATTHEW J. WALTER J.H.H., TOWER 110   |   |  |                    |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 08 1996  |   | 32. Registrar's Signature<br>John H. H. H.   |                    |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Amend #1 Wash. Co. Health Dept. XB 04-1967612389

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Paul Junior Rickard Junior</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 10, 1996</b>   |  | 3. TIME OF DEATH<br><b>1:31 A<sup>M</sup></b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-14-2627</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 2, 1925</b>                                 |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Avalon Manor Home, Inc.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>514 Ridge Avenue</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W.II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4 or 5+) <b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>welder</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>sand blast</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clayton Rickard</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Keplinger</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thomas C. Rickard</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>335 McDowell Ave., Hagerstown, Md. 21740</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park 4-12-96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  | 20d. DATE<br><b>4-12-96</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott Minnich</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>sepsis</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>urinary tract infection</b><br>c. DUE TO (OR AS A CONSEQUENCE OF): <b>pneumonia</b><br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2-3 days</b><br><b>2-3 days</b><br><b>2-3 days</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure, arteriosclerosis, cardiac arrhythmia, chronic obstructive pulmonary disease, diabetes mellitus</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Vasant Datta</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18019</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 10, 1996</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Vasant Datta, 334 Mill St., Hagerstown, Md. 21740</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 10 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Swanson</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12390

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HOLLIS RIGGIN</b>   |   |  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>9</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>9: 27 AM</b>                                     |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center; Genesis ElderCare</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Salisbury, Md.</b>  |   | 4c. County of Death<br><b>WICOMICO</b>                                  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-32-0800</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | If Under 1 Year<br>Months Days                  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>02/02/1912</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|  | Usual Residence of Decedent  |   |  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>WICOMICO</b>  |   | 10c. City, Town or Location<br><b>SALISBURY</b>  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   | 10e. Street and Number<br><b>200 CIVIC AVENUE</b>  |   | 10f. Zip Code<br><b>21801</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TIMBERMAN/POULTRY GROWER</b>       |   | 16b. Kind of Business/Industry<br><b>FORESTRY/AGRICULTURE</b>  |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM A. RIGGIN</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NORA RICHARDSON</b>  |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROGER L. RICHARDSON</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1947 OLD FURNACE ROAD, EDEN, MD. 21822</b>   |   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MANOKIN PRESBYTERIAN CEM.</b>   |   | Date<br><b>4/13</b>  |   | 20c. Location - City or Town, State<br><b>PRINCESS ANNE, MD.</b>        |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>MO0295</b>  |   |  |   | 22. Name and Address of Facility<br><b>HINMAN FUNERAL HOME</b><br><b>11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853</b>   |   |   |   |  |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Advanced Dementia</b><br>Due to (or as a consequence of):<br><b>Cerebral Vascular Disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |   |  |   |   |   | Approximate Interval Between Onset and Death<br><b>years 8</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Recent Right Hip Fracture</b><br><b>LTN Cerebral Vascular Disease</b>   |   |  |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                 |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D-39813</b>           |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/96</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR, SALISBURY, MD. 21804</b>   |  |   |  |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 12391

Reg. No.

|                                     |  |  |   |  |  |  |  |  |  |  |   |  |
|-------------------------------------|--|--|---|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Wilmer C. Russell, Sr.   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 12 1996  |  | 3. Time of Death<br>0240   |  |  |  |   |  |
|                                     | 4a. Facility Name (If not Institution, give street and number)<br>Union Hospital of Cecil County   |  |   |  | 4b. City, Town, or Location of Death<br>Elkton   |  | 4c. County of Death<br>Cecil   |  |  |  |   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>214-22-9948   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 20, 1927  |  |  |  |   |  |
|                                     | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10. Usual Residence of Decedent<br>10a. State: Maryland 10b. County: Cecil 10c. City, Town or Location: Elkton  |  | 11. Merit Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II  |  |  |  |   |  |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver  |  |  |  |   |  |
|                                     | 16b. Kind of Business/Industry<br>Transportation   |  | 17. Father's Name (First, Middle, Last)<br>Chester A. Russell, Sr.  |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br>Alice E. Hamilton  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Audrey A. Russell  |  |  |  |   |  |
|                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>124 Castlestone Drive - Elkton, MD 21921  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gilpin Manor Memorial Park   |  | 20c. Location - City or Town, State<br>Elkton, Maryland  |  |  |  |   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Daniel S. Hicks</i>  |  | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, MD 21921-5521   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebral herniation<br>Due to (or as a consequence of):<br>b. Massive (R) MCA CVA.<br>Due to (or as a consequence of):<br>c. Cerebrovascular disease<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.<br>n.<br>o.<br>p.<br>q.<br>r.<br>s.<br>t.<br>u.<br>v.<br>w.<br>x.<br>y.<br>z.<br>aa.<br>ab.<br>ac.<br>ad.<br>ae.<br>af.<br>ag.<br>ah.<br>ai.<br>aj.<br>ak.<br>al.<br>am.<br>an.<br>ao.<br>ap.<br>aq.<br>ar.<br>as.<br>at.<br>au.<br>av.<br>aw.<br>ax.<br>ay.<br>az.<br>ba.<br>bb.<br>bc.<br>bd.<br>be.<br>bf.<br>bg.<br>bh.<br>bi.<br>bj.<br>bk.<br>bl.<br>bm.<br>bn.<br>bo.<br>bp.<br>bq.<br>br.<br>bs.<br>bt.<br>bu.<br>bv.<br>bw.<br>bx.<br>by.<br>bz.<br>ca.<br>cb.<br>cc.<br>cd.<br>ce.<br>cf.<br>cg.<br>ch.<br>ci.<br>cj.<br>ck.<br>cl.<br>cm.<br>cn.<br>co.<br>cp.<br>cq.<br>cr.<br>cs.<br>ct.<br>cu.<br>cv.<br>cw.<br>cx.<br>cy.<br>cz.<br>da.<br>db.<br>dc.<br>dd.<br>de.<br>df.<br>dg.<br>dh.<br>di.<br>dj.<br>dk.<br>dl.<br>dm.<br>dn.<br>do.<br>dp.<br>dq.<br>dr.<br>ds.<br>dt.<br>du.<br>dv.<br>dw.<br>dx.<br>dy.<br>dz.<br>ea.<br>eb.<br>ec.<br>ed.<br>ee.<br>ef.<br>eg.<br>eh.<br>ei.<br>ej.<br>ek.<br>el.<br>em.<br>en.<br>eo.<br>ep.<br>eq.<br>er.<br>es.<br>et.<br>eu.<br>ev.<br>ew.<br>ex.<br>ey.<br>ez.<br>fa.<br>fb.<br>fc.<br>fd.<br>fe.<br>ff.<br>fg.<br>fh.<br>fi.<br>fj.<br>fk.<br>fl.<br>fm.<br>fn.<br>fo.<br>fp.<br>fq.<br>fr.<br>fs.<br>ft.<br>fu.<br>fv.<br>fw.<br>fx.<br>fy.<br>fz.<br>ga.<br>gb.<br>gc.<br>gd.<br>ge.<br>gf.<br>gg.<br>gh.<br>gi.<br>gj.<br>gk.<br>gl.<br>gm.<br>gn.<br>go.<br>gp.<br>gq.<br>gr.<br>gs.<br>gt.<br>gu.<br>gv.<br>gw.<br>gx.<br>gy.<br>gz.<br>ha.<br>hb.<br>hc.<br>hd.<br>he.<br>hf.<br>hg.<br>hi.<br>hj.<br>hk.<br>hl.<br>hm.<br>hn.<br>ho.<br>hp.<br>hq.<br>hr.<br>hs.<br>ht.<br>hu.<br>hv.<br>hw.<br>hx.<br>hy.<br>hz.<br>ia.<br>ib.<br>ic.<br>id.<br>ie.<br>if.<br>ig.<br>ih.<br>ii.<br>ij.<br>ik.<br>il.<br>im.<br>in.<br>io.<br>ip.<br>iq.<br>ir.<br>is.<br>it.<br>iu.<br>iv.<br>iw.<br>ix.<br>iy.<br>iz.<br>ja.<br>jb.<br>jc.<br>jd.<br>je.<br>jf.<br>jg.<br>jh.<br>ji.<br>jj.<br>jk.<br>jl.<br>jm.<br>jn.<br>jo.<br>jp.<br>jq.<br>jr.<br>js.<br>jt.<br>ju.<br>jv.<br>jw.<br>jx.<br>jy.<br>jz.<br>ka.<br>kb.<br>kc.<br>kd.<br>ke.<br>kf.<br>kg.<br>kh.<br>ki.<br>kj.<br>kl.<br>km.<br>kn.<br>ko.<br>kp.<br>kq.<br>kr.<br>ks.<br>kt.<br>ku.<br>kv.<br>kw.<br>kx.<br>ky.<br>kz.<br>la.<br>lb.<br>lc.<br>ld.<br>le.<br>lf.<br>lg.<br>lh.<br>li.<br>lj.<br>lk.<br>ll.<br>lm.<br>ln.<br>lo.<br>lp.<br>lq.<br>lr.<br>ls.<br>lt.<br>lu.<br>lv.<br>lw.<br>lx.<br>ly.<br>lz.<br>ma.<br>mb.<br>mc.<br>md.<br>me.<br>mf.<br>mg.<br>mh.<br>mi.<br>mj.<br>mk.<br>ml.<br>mm.<br>mn.<br>mo.<br>mp.<br>mq.<br>mr.<br>ms.<br>mt.<br>mu.<br>mv.<br>mw.<br>mx.<br>my.<br>mz.<br>na.<br>nb.<br>nc.<br>nd.<br>ne.<br>nf.<br>ng.<br>nh.<br>ni.<br>nj.<br>nk.<br>nl.<br>nm.<br>nn.<br>no.<br>np.<br>nq.<br>nr.<br>ns.<br>nt.<br>nu.<br>nv.<br>nw.<br>nx.<br>ny.<br>nz.<br>oa.<br>ob.<br>oc.<br>od.<br>oe.<br>of.<br>og.<br>oh.<br>oi.<br>oj.<br>ok.<br>ol.<br>om.<br>on.<br>oo.<br>op.<br>oq.<br>or.<br>os.<br>ot.<br>ou.<br>ov.<br>ow.<br>ox.<br>oy.<br>oz.<br>pa.<br>pb.<br>pc.<br>pd.<br>pe.<br>pf.<br>pg.<br>ph.<br>pi.<br>pj.<br>pk.<br>pl.<br>pm.<br>pn.<br>po.<br>pp.<br>pq.<br>pr.<br>ps.<br>pt.<br>pu.<br>pv.<br>pw.<br>px.<br>py.<br>pz.<br>qa.<br>qb.<br>qc.<br>qd.<br>qe.<br>qf.<br>qg.<br>qh.<br>qi.<br>qj.<br>qk.<br>ql.<br>qm.<br>qn.<br>qo.<br>qp.<br>qq.<br>qr.<br>qs.<br>qt.<br>qu.<br>qv.<br>qw.<br>qx.<br>qy.<br>qz.<br>ra.<br>rb.<br>rc.<br>rd.<br>re.<br>rf.<br>rg.<br>rh.<br>ri.<br>rj.<br>rk.<br>rl.<br>rm.<br>rn.<br>ro.<br>rp.<br>rq.<br>rr.<br>rs.<br>rt.<br>ru.<br>rv.<br>rw.<br>rx.<br>ry.<br>rz.<br>sa.<br>sb.<br>sc.<br>sd.<br>se.<br>sf.<br>sg.<br>sh.<br>si.<br>sj.<br>sk.<br>sl.<br>sm.<br>sn.<br>so.<br>sp.<br>sq.<br>sr.<br>ss.<br>st.<br>su.<br>sv.<br>sw.<br>sx.<br>sy.<br>sz.<br>ta.<br>tb.<br>tc.<br>td.<br>te.<br>tf.<br>tg.<br>th.<br>ti.<br>tj.<br>tk.<br>tl.<br>tm.<br>tn.<br>to.<br>tp.<br>tq.<br>tr.<br>ts.<br>tu.<br>tv.<br>tw.<br>tx.<br>ty.<br>tz.<br>ua.<br>ub.<br>uc.<br>ud.<br>ue.<br>uf.<br>ug.<br>uh.<br>ui.<br>uj.<br>uk.<br>ul.<br>um.<br>un.<br>uo.<br>up.<br>uq.<br>ur.<br>us.<br>ut.<br>uu.<br>uv.<br>uw.<br>ux.<br>uy.<br>uz.<br>va.<br>vb.<br>vc.<br>vd.<br>ve.<br>vf.<br>vg.<br>vh.<br>vi.<br>vj.<br>vk.<br>vl.<br>vm.<br>vn.<br>vo.<br>vp.<br>vq.<br>vr.<br>vs.<br>vt.<br>vu.<br>vv.<br>vw.<br>vx.<br>vy.<br>vz.<br>wa.<br>wb.<br>wc.<br>wd.<br>we.<br>wf.<br>wg.<br>wh.<br>wi.<br>wj.<br>wk.<br>wl.<br>wm.<br>wn.<br>wo.<br>wp.<br>wq.<br>wr.<br>ws.<br>wt.<br>wu.<br>wv.<br>ww.<br>wx.<br>wy.<br>wz.<br>xa.<br>xb.<br>xc.<br>xd.<br>xe.<br>xf.<br>xg.<br>xh.<br>xi.<br>xj.<br>xk.<br>xl.<br>xm.<br>xn.<br>xo.<br>xp.<br>xq.<br>xr.<br>xs.<br>xt.<br>xu.<br>xv.<br>xw.<br>xx.<br>xy.<br>xz.<br>ya.<br>yb.<br>yc.<br>yd.<br>ye.<br>yf.<br>yg.<br>yh.<br>yi.<br>yj.<br>yk.<br>yl.<br>ym.<br>yn.<br>yo.<br>yp.<br>yq.<br>yr.<br>ys.<br>yt.<br>yu.<br>yv.<br>yw.<br>yx.<br>yy.<br>yz.<br>za.<br>zb.<br>zc.<br>zd.<br>ze.<br>zf.<br>zg.<br>zh.<br>zi.<br>zj.<br>zk.<br>zl.<br>zm.<br>zn.<br>zo.<br>zp.<br>zq.<br>zr.<br>zs.<br>zt.<br>zu.<br>zv.<br>zw.<br>zx.<br>zy.<br>zz. |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |
|                                     | 28a. Date of Injury (Month, Day, Year)   |  |   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
|                                     | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |  | 29c. License number<br>D45155  |  |   |  |
|                                     | 29d. Data signed (Month, Day, Year)<br>April 12, 1996  |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>John Mulvey M.D. 118 North St. Ste 2A Elkton, Md 21921   |  |  |  |  |  |   |  |
|                                     | 31. Data filed (Month, Day, Year)<br>APR 16 1996   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |   |  |

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME: Wilmer Russell  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

7  
+1VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12392

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLELA MAE . RUSH

2. Date of Death

Month Day Year  
March 29, 1996

3. Time of Death

3:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Vindabona Nursing Home

4b. City, Town, or Location of Death

Braddock Heights

4c. County of Death

Frederick

5. Social Security Number

234-10-2777

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 2, 1907

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1421 Taney Ave.

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

District Cashier

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

Ulysses Grant Forester

18. Mother's Name (First, Middle, Maiden Surname)

Stella

Cork

19a. Informant's Name/Relationship (Type, Print)

Helen D. Grimmatt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8802-A Mapleville Rd. / Libertytown, Md. 21762

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Shinnstown Masonic

Date

4-1-96

20c. Location - City or Town, State

Shinnston, W. Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CVA - Recurrent  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-13971

29d. Date signed (Month, Day, Year)

April 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Kaufmann / 300 W. 9th St. / Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

APR 02 1996

32. Registrar's Signature

John Davidson-RandallState  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



AMENDED # 198, See, ACHD, 4-11-96

96 12393

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN T. SUMMERS  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 6 1996  |  | 3. TIME OF DEATH<br>17:55 M   |  |
| 4. SOCIAL SECURITY NUMBER<br>176-32-7333   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>56 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 21, 1939  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MEMORIAL HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CUMBERLAND   |  | 9c. COUNTY OF DEATH<br>ALLEGANY   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>WEST VA  |  | 10b. COUNTY<br>MINERAL   |  | 10c. CITY, TOWN OR LOCATION<br>KEYSER   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>ROUTE 1, BOX 116   |  |  |  | 10f. ZIP CODE<br>26726  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>OPER. TRAINING ANALYST  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>WESTVACO PAPER MANUFACTURING                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN T. SUMMERS   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGARET R. BRESSLER   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>PATRICIA ANN (UPDIKE) SUMMERS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>ROUTE 1, BOX 116 - KYSER, WV 26726   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br>BALD EAGLE CEMETERY 4/10/96  |  | 20c. LOCATION — City or Town, State<br>SNYDER TWP., PA  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>George N. Upchurch  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br>202 GREENE ST., CUMBERLAND, MD 21502  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dissecting Thoracic Aortic Aneurysm with Rupture<br>e. into Mediastinum<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Right Coronary Artery Disease due to Atherosclerosis.<br>New onset of Angina<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>N. Saheta MD  |  |  |  | 29c. LICENSE NUMBER<br>D 17920  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 9 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Narayan Saheta M.D. Memorial Hospital Cumberland, MD 21502  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 11 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John D. ...  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12394

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |
|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DESIREE STRASSBERGER</b>  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>11</b> YEAR <b>1996</b>  |   | 3. TIME OF DEATH<br><b>0915</b> a m   |
| 4. SOCIAL SECURITY NUMBER<br><b>none</b>   | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>YRS. <b>5</b> MONTHS <b>23</b> DAYS <b>5</b> HOURS <b>23</b> MIN.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/11/96</b> |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |   | 8c. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |
| 9a. RESIDENCE OF DECEDENT<br>10a. STATE <b>MARYLAND</b> 10b. COUNTY <b>MONTGOMERY</b> 10c. CITY, TOWN OR LOCATION <b>DAMASCUS</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |   |   |
| 10e. STREET AND NUMBER<br><b>9817 BETHESDA CHURCH ROAD APT 302</b>   |  | 10f. ZIP CODE<br><b>20872</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LARRY MINER</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY JO STRASSBERGER</b>   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY JO STRASSBERGER</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9817 BETH. CHURCH RD, #302, DAMASCUS, MD 20872</b>   |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SHADY GROVE ADVENT. HOSP. 4/96</b>   |   | 20c. LOCATION — City or Town, State<br><b>ROCKVILLE, MD</b>   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>M. Peterson-V. Pres.</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SHADY GROVE ADVENTIST HOSPITAL 3395<br/>9901 MED. CTR. DR., ROCKVILLE, MD 20850-</b>  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. CARDIO RESPIRATORY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CONGENITAL CENTRAL NERVOUS SYSTEM ANOMALY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. HOLOPROSENCEPHALY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |   | Approximate Interval Between Onset and Death<br><b>5hrs and 23 mins.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |
|  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>incomplete</b>                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                       | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>NEONATOLOGIST</i>  |   |   |
| 29c. LICENSE NUMBER<br><b>29518</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 11, 1996</b>   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SITH SADHASIVAN, MD 9901 MED. CTR. DRIVE, ROCKVILLE, MD 20850-3395</b>   |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 25 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Henderson</i>  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10

REG. NO.

DHMH-18 Rev 1/89

09

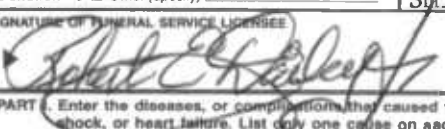
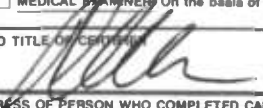

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IRENE HORDA SKALSKY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>25</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>6:15 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>150-24-0607</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 13, 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ukraine</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Northampton Manor Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>200 East Sixteenth Street</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21701</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Gregory Horda</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Dudkovsky</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Askold Skalsky</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2328 Oak Drive, Ijamsville, Maryland 21754</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 NORTH MARKET ST. FREDERICK, MD 21701</b>     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>post pneumonia</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D26 499</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/26/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ronald E. Miller, MD 4 Culwell Drive, Mt. Airy, Maryland 21771</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 26 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96-1775-033

UNK. #96-70

CMK ITEMS: 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene

FILM G-734 4/29/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

## Certificate of Death

Reg. No.

96 12397

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILSON

R.

SISTRUNK

2. Date of Death

Month

Day

Year

APRIL 02, 1996

3. Time of Death

1630 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

K-9 TRAINING FIELD-COUNTY JAIL

4b. City, Town, or Location of Death

UPPER MARLBORO

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-72-9605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11/13/54

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1430 Saratoga Ave., N.E. # 2

10f. Zip Code

20018

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Maintenance Man

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Booker T. Sistrunk

18. Mother's Name (First, Middle, Maiden Surname)

Isabell Scruggs

19a. Informant's Name/Relationship (Type, Print)

Rudolph Sistrunk - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Mem. Park 4/10/96

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Mary H. Pratt

22. Name and Address of Facility

H.S. Washington &amp; Sons, Inc.

4925 Burroughs Ave., N.E.

Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

KETOACIDOSIS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☒ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary H. Pratt

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 03, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. A. R. M. O. N. S. K. O. W. N. M. P.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 12 1996

32. Registrar's Signature

John M. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

APR 15 1988




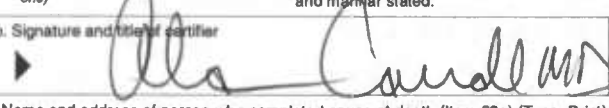
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12398

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |   |   |   |  |
|---|---|---|--|---|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>SAM HAWKINS STARBUCK, JR.               |   |  |   | 2. Date of Death<br>Month Day Year<br>April 6, 1996 |   | 3. Time of Death<br>8:00 P.M.   |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>32 Frederick Road |   |  |   | 4b. City, Town, or Location of Death<br>Thurmont    |   | 4c. County of Death<br>Frederick  |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-32-5847  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>April 20, 1914                                   | 9. Birthplace (State or Foreign Country)<br>Tennessee   |   |  |
|   | Usual Residence of Decedent   |   |  |   |   |   |   |   |   |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Thurmont   |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |  |
| 10e. Street and Number<br>32 Frederick Road   |   |   |  | 10f. Zip Code<br>21788  |   | 10g. Citizen of What Country?<br>United States  |   |   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                        |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) +1   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk  |   |   | 16b. Kind of Business/Industry<br>U.S. Post Office                                      |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Sam Hawkins Starbuck, Sr.  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Charlie Watson   |   |   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Paula M. Harbaugh, daughter   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>36 Frederick Road Thurmont, MD 21788   |   |   |   |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Blue Ridge Cemetery   |  | Data<br>4/9/96  |   | 20c. Location - City or Town, State<br>Thurmont, Maryland   |   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>104 East Main Street Thurmont, MD 21788   |   |   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Small Cell Cancer of Lung</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Emphysema</u><br><u>Coronary artery disease</u> |   |   |  |   |   |   |   | Approximate Interval Between Onset and Death<br>5 mo.   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |   |   |   |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |   | 28d. Describe how injury occurred   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><br>29c. License number<br>D18705   |  |   |   |   |   |   | 29d. Date signed (Month, Day, Year)<br>4/8/96 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Alan L. Carroll, M.D. 310 S. Seton Ave. Emmitsburg, MD 21727  |   |   |  |   |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 08 1996  |   | 32. Registrar's Signature<br>  |  |   |   |   |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Margaret R. Schaumburg</i>  |  |  |  | 2. DATE OF DEATH <i>APRIL 14, 1996</i>   |  | 3. TIME OF DEATH<br><i>7:10 A.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>087-16-3740</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>89</i> YRS.   |  | 7. DATE OF BIRTH<br><i>09-21-06</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Bronx NY</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Charles County Nursing and Rehab Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>La Plata</i>   |  |
| 9c. COUNTY OF DEATH<br><i>Charles</i>  |  |  |  | 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Charles</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>LaPlata</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>8270 Fairgrounds Rd.</i>  |  |
| 10f. ZIP CODE<br><i>20646</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <i>White</i>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i><br><i>12</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Accountant</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>N.O.S.</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John O'Keefe</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret Kelly O'Keefe</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type, Print)<br><i>Margaret Steinhauser</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8270 Fairgrounds Rd. LaPlata, MD 20646</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arlington Nat. Cem. 4/23/96</i>  |  | 20c. LOCATION — City or Town, State<br><i>Arlington, VA</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David P. Echols</i> MO0945   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>AREHART-ECHOLS FUNERAL HOME, INC.</i><br><i>P.O. Box 567 LaPlata, MD 20646</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. <i>Atherosclerosis</i>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. _____   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. _____   |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive Lung Disease</i><br><i>Dementia</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>E. S. Neeth attending physician</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D12587</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4-14-96</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 16 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 12400

|   |  |  |   |   |  |   |  |  |
|---|--|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>EDITH MAY SHIFLETT   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 6, 1996  |   | 3. Time of Death<br>12:40 AM   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Memorial Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Cumberland   |   | 4c. County of Death<br>Allegany  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-14-6270   |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>JUNE 29 1921  |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br>W.VA.   |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND   |  | 10b. County<br>ALLEGANY   |   | 10c. City, Town or Location<br>CUMBERLAND  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 10e. Street and Number<br>105 BELLEVUE STREET  |  |   |   | 10f. Zip Code<br>21502   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>FOOTERS CLEANERS   |   |  | 16b. Kind of Business/Industry<br>CLOTHING/CLEANING   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>JOHN THOMPSON   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MAY ELIZABETH ANDERSON  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>KATHLEEN CHASTAIN  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2812 WEST POWHATAN AVE TAMPA, FLA. 33614  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>REST LAWN CEMETERY  |   | Date<br>APRIL 9 1996   |   | 20c. Location - City or Town, State<br>LAVALLE, MARYLAND   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Dale L. Merritt</i>  |  |   |   | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME<br>404 DECATUR STREET CUMBERLAND MARYLAND   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute exacerbation of COPD<br>Due to (or as a consequence of):<br>b. Chronic obstructive pulmonary disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>1 day<br>> 20 years |  |   |   |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |
|   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  |  | 28d. Describe how injury occurred   |   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   | 29c. License number<br>D 23371   |   | 29d. Date signed (Month, Day, Year)<br>April 8 1996  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502 |  |  |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 9 1996   |  |  |   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12401

|   |   |   |   |  |  |  |  |   |  |
|---|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MABEL DRUSELLA SHROYER  |   |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 4, 1996  |  | 3. Time of Death<br>11:00 pm   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>24 PARKSIDE BLVD  |   |   |  | 4b. City, Town, or Location of Death<br>LAVALE   |  | 4c. County of Death<br>ALLEGANY  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-34-2582  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>87 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>AUG 18, 1908  |  | 9. Birthplace (State or Foreign Country)<br>PENNSYLVANIA  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  | 10b. County<br>ALLEGANY   |   | 10c. City, Town or Location<br>LAVALE  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>24 PARKSIDE BLVD  |   |   | 10f. Zip Code<br>21502   |  | 10g. Citizen of What Country?<br>USA   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+)  |   |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LABORER |  | 18b. Kind of Business/Industry<br>LAUNDRY  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>IRVIN H. LOGSDON   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>BESSIE BEAL   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>SHIRLEY R. FICHTNER   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24 PARKSIDE BLVD, LAVALE, MD 21502  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PALO ALTO CEMETERY  |  | Date<br>APRIL 8, 1996  |  | 20c. Location - City or Town, State<br>RD, HYNDMAN, PA 15545                                       |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Harvey H. Zeigler</i>   |   |   |  | 22. Name and Address of Facility<br>HARVEY H. ZEIGLER FUNERAL HOME<br>HYNDMAN, PA 15545-0636   |  |  |   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |   | Approximate Interval Between Onset and Death |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. SEPSIS<br>Due to (or as a consequence of):<br>b. PNEUMONIA<br>Due to (or as a consequence of):<br>c. CEREBRAL VASCULAR ACCIDENT<br>Due to (or as a consequence of):<br>d. ARTERIOSCLEROTIC VASCULAR DISEASE |   |   |  |  |  |  |   | 24 Hours<br>1 WEEK<br>2 YEARS<br>10 YEARS    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |   |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Gregg L. Donaldson</i>  |   | 29c. License number<br>MD 023894-E  |   | 29d. Date signed (Month, Day, Year)<br>4/5/96  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>GREGG L. DONALDSON, MD, HAH, HYNDMAN, PA 15545  |   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 05 1996  |   | 32. Registrar's Signature<br><i>John H. ...</i>   |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





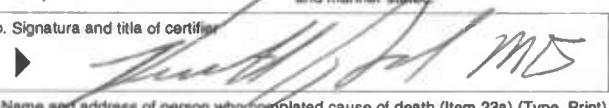
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12402

## Certificate of Death

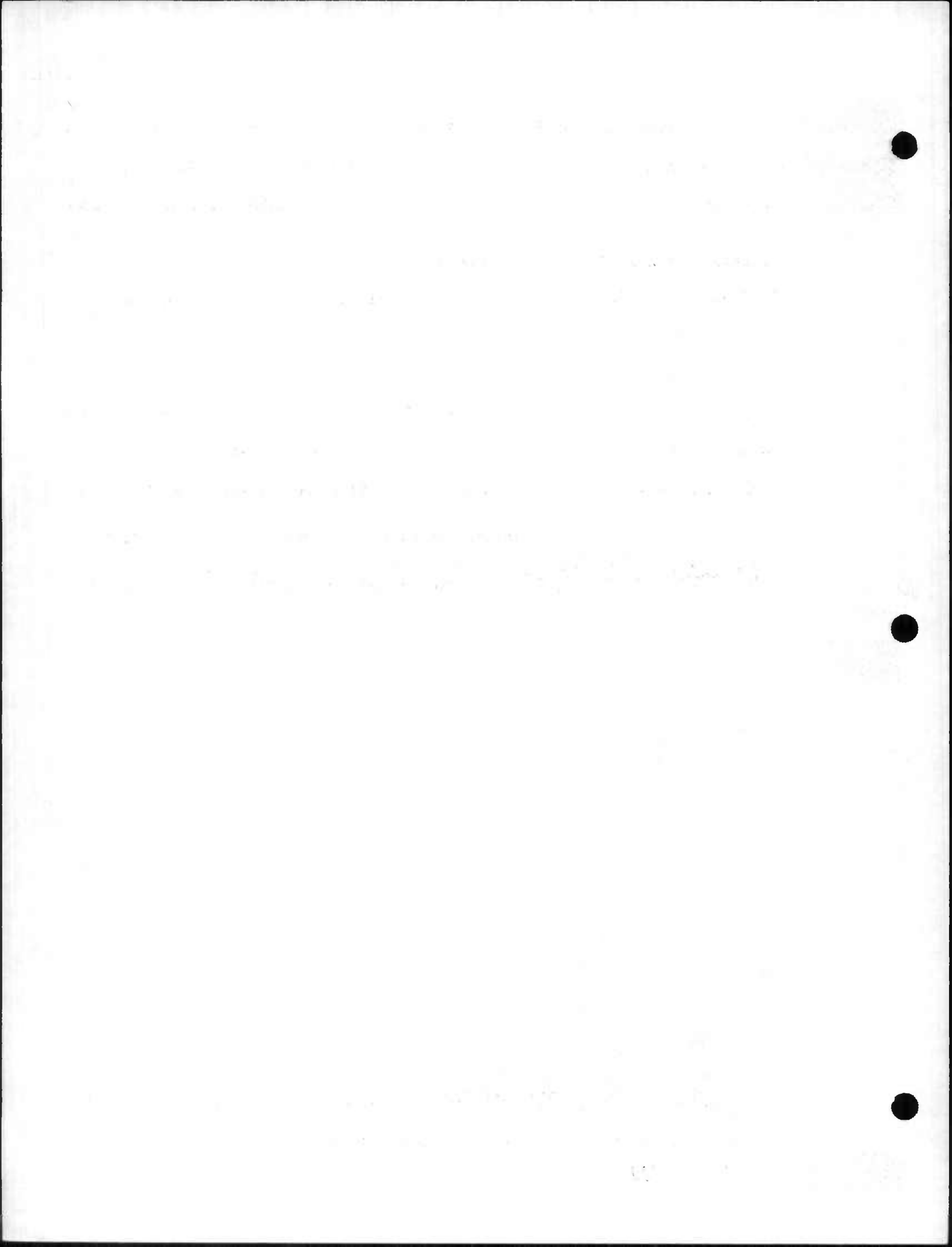
Reg. No.

|  |  |  |  |  |   |   |   |  |
|--|--|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARSHALL ALLEN SPIKER</b>                   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 14, 1996</b> |   | 3. Time of Death<br><b>3:50 PM</b>                          |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Memorial Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |   | 4c. County of Death<br><b>Allegany</b>                      |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-28-0451</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 12, 1931</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ALLEGANY</b>                              |   | 10c. City, Town or Location<br><b>LAVALE</b>                |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>11127 DUBLIN STREET NW</b>  |  | 10f. Zip Code<br><b>21502</b>  |   | 10g. Citizen of What Country?<br><b>U S A</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1952 to 1960</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> Collage (1-4 or 5+) <b>LABORER</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>            |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES SPIKER</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NORA SPIKER</b>  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GOLDIE T. SPIKER</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11127 DUBLIN STREET NW LAVALE, MARYLAND 21502</b>  |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTLAWN MEMORIAL GARDENS 4/17</b>                        |  | 20c. Location - City or Town, State<br><b>LAVALE, MARYLAND</b>   |   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>HAFFER CHAPEL OF THE HILLS MORTUARY<br/>1302 NATIONAL HWY LAVALE, MARYLAND 21502</b>            |  |  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Adenocarcinoma of the Colon</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 30159</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 15<sup>th</sup> 1996</b>   |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. K. Rock, Memorial Hospital, Cumberland, MD 21502</b>  |  |  |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 19 1996</b>  |  | 32. Registrar's Signature<br>                       |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12403

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |   |
|---|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ROBERT N. KREIGER  |   |  |  | 2. Date of Death<br>Month Day Year<br>April 16, 1996 |  | 3. Time of Death<br>05:55 AM   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital & Medical Center |   |  |  | 4b. City, Town, or Location of Death<br>Cumberland   |  | 4c. County of Death<br>Allegany  |   |
| Funeral<br>Director   | 5. Social Security Number<br>215-20-6971   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>69 Yrs.  | If Under 1 Year<br>Months - Days                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Nov 15, 1926  | 9. Birthplace (State or Foreign Country)<br>MD                              |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br>MD  |  | 10b. County<br>Allegany   |  | 10c. City, Town or Location<br>Cresaptown  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br>P.O. Box 5223   |  |   |  | 10f. Zip Code<br>21502   |  | 10g. Citizen of What Country?<br>USA   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)   |  |   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retired   |  | 16b. Kind of Business/Industry<br>MD State Employment  |  |   |
| 17. Father's Name (First, Middle, Last)<br>William C. Kreiger   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Cecelia K. (Davis)  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Clara Kreiger--wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 5223; Cresaptown, MD 21502   |  |  |  |   |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rocky Gap Veterans Cem  |  | Date<br>04/19  |  | 20c. Location - City or Town, State<br>Flintstone, MD  |  |   |
| 21. Signature of Funeral Service Licensee<br>James F. Scarpelli   |  |   |  | 22. Name and Address of Facility<br>Scarpelli Funeral Home<br>Cumberland, MD 21502   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Richter syndrome; non-Hodgkins Lymphoma<br>Due to (or as a consequence of):<br>b. Acute Renal Failure<br>Due to (or as a consequence of):<br>c. Nodular Poorly Differentiated Lymphoma<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>2 months<br>2 weeks<br>1992 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br>[Signature] MD   |  |   |  | 29c. License number<br>D23371  |  | 29d. Date signed (Month, Day, Year)<br>April 17 1996   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DR. Qamar Zaman Johnson Heights Medical Building Cumberland, MD. 21502  |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 18 1996  |  | 32. Registrar's Signature<br>Julia Anderson-Randall   |  |  |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 12404

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Francis Sanders</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>16</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>11:00 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-14-4467</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 1, 1908</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Goodwill Mennonite Home</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Grantsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Garrett</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Garrett</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Grantsville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1825 Pigs Ear Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21536</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>3</b> College (1-4 or 5+) <b>3</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Sanders</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Engle</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy I. George</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1789 Pigs Ear Road; Grantsville, MD 21536</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Paul's Cemetery April 19</b>  |  | 20c. LOCATION — City or Town, State<br><b>Accident, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Newman Funeral Homes, P.A.; P.O. Box 275<br/>Grantsville, Maryland 21536</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Stroke</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 weeks</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease.<br/>Congestive Heart Failure.</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |   |  | 29c. LICENSE NUMBER<br><b>D34079</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 16 1996</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James E Bertzel MD Grantsville MD 21536</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 18 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12405

## Certificate of Death

Reg. No.

Statistics

|   |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|---|---|--|---|---------------------------------------|--|---|---|---|--|--|---|---|------------|---|------------|--|----------|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA LEE SMITH</b>   |  |   |                                       |  |   | 2. Date of Death<br>Month Day Year<br><b>April 12, 1996</b>                   |   | 3. Time of Death<br><b>10:05 AM</b>  |  |   |   |            |   |            |  |          |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |   |                                       |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                     |   | 4c. County of Death<br><b>Allegany</b>   |  |   |   |            |   |            |  |          |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>234-38-8209</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1929</b>                     |   | 9. Birthplace (State or Foreign Country)<br><b>WV</b>  |  |   |   |            |   |            |  |          |    |
|   | Usual Residence of Decedent   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| To Be Completed by Funeral Director   | 10a. State<br><b>WV</b>   |  | 10b. County<br><b>Hampshire</b>   |                                       | 10c. City, Town or Location<br><b>Greenspring</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |            |   |            |  |          |    |
|   | 10e. Street and Number<br><b>P.O. Box 28</b>  |  |   |                                       | 10f. Zip Code<br><b>26722</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                   |   |  |  |   |   |            |   |            |  |          |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |   |   |            |   |            |  |          |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>12</b>   |  |   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |   |   |            |   |            |  |          |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>Russell Earl Stewart</b>  |  |   |                                       |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Beulah May (Dayton)</b> |   |  |  |   |   |            |   |            |  |          |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Benny Cadwalder--daughter</b>  |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>H.C. 86 Box 50A1, Greenspring, WV 26722</b>  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forest Glen Cemetery</b>   |                                       | Date<br><b>04/15</b>   |   | 20c. Location - City or Town, State<br><b>Greenspring, WV</b>                 |   |  |  |   |   |            |   |            |  |          |    |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                                       | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Advanced non-small cell Carcinoma of the Lung</b><br/>Due to (or as a consequence of):</td> <td>Early 1995</td> </tr> <tr> <td>b. <b>Bone-Metastasis</b><br/>Due to (or as a consequence of):</td> <td>Early 1995</td> </tr> <tr> <td>c. <b>Aspiration Pneumonia</b><br/>Due to (or as a consequence of):</td> <td>One Week</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |                                       |  |   |   |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Advanced non-small cell Carcinoma of the Lung</b><br>Due to (or as a consequence of): | Early 1995 | b. <b>Bone-Metastasis</b><br>Due to (or as a consequence of): | Early 1995 | c. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of): | One Week | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Advanced non-small cell Carcinoma of the Lung</b><br>Due to (or as a consequence of):   | Early 1995   |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | b. <b>Bone-Metastasis</b><br>Due to (or as a consequence of):   | Early 1995   |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | c. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):  | One Week   |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
|   | d.  |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 26. Place of Death (Check only one)<br>Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |  |   |   |            |   |            |  |          |    |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |   |  |  |   |   |            |   |            |  |          |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 29b. Signature and title of certifier<br><br><b>MD</b>   |   |  |   | 29c. License number<br><b>D 23371</b> |  | 29d. Date signed (Month, Day, Year)<br><b>April 15, 1996</b>                                |   |   |  |  |   |   |            |   |            |  |          |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>  |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1996</b><br>Registrar's Signature<br>   |   |  |   |                                       |  |   |   |   |  |  |   |   |            |   |            |  |          |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12406**  
Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES EVERETT SNIDER</b>                  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 11, 1996</b>   |  |  |  | 3. Time of Death<br><b>11:35 A</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  |  |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-10-7037</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 22, 1920</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>   |   | 10c. City, Town or Location<br><b>Cumberland</b>   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>520 Winifred Road</b>   |  |  |   | 10f. Zip Code<br><b>21502</b>  |   |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II &amp; Korea</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired detective/sgt.</b>   |   |  |  | 16b. Kind of Business/Industry<br><b>Cumberland Police Dept</b>                                |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Charles Snider</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Marie (Darcy)</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth Snider--son</b>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>520 Winifred Road; Cumberland, MD 21502</b> |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Park</b>  |  |   | 20c. Location - City or Town, State<br><b>04/13 Cumberland, MD</b> |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Nicholas J. Scarpelli</i>  |  |  |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Malignant Ventricular arrhythmia</b><br>Dua to (or as a consequence of):<br><b>b. Dilated Cardiomyopathy</b><br>Dua to (or as a consequence of):<br><b>c.</b><br>Dua to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>1 hour</b><br><b>5 years</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>COPD, Sex</b>   |  |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>N.A. Ranj, M.D.</i>  |  |  |   |  | 29c. License number<br><b>D 23334 (D19318)</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 12 1996</b>                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>DINESH SHAH M.D., P.O. BOX 131, PINTO, MD. 21556</b>  |  |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1996</b>  |  |  |   |  | 32. Registrar's Signature<br><i>John Anderson-Randall</i>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 12407

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALMA VIRGINIA SEIB</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 9, 1996</b>  |  | 3. TIME OF DEATH<br>M<br><b>6:06 P.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216225929</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 4, 1910</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>   |  |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Allegany</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Lonaconing</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>57 Charlestown St.</b>  |  |
| 10f. ZIP CODE<br><b>21539</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lounge</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Le Roy Easter</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edna Maud Lung</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edna Lewis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Beachside BLVD, Chippewa Lake, Ohio 44215</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Josephs Cemetery April 13, 1996 Midland, Md.</b>  |  |  |  |
| 20c. LOCATION — City or Town, State   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Mike</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Richhorn-McKenzie Funeral Home<br/>Lonaconing, Md. 21539</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Atherosclerotic coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>M</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>1</b> YES 2 <input type="checkbox"/> NO   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas J. Devlin M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D21488</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>4-10-96</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas J. Devlin M.D.; 20 Douglas Ave, Lonaconing, Md 21539</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12408

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Anna Elizabeth Scott  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 10, 1996  |  | 3. TIME OF DEATH<br>2:25 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-36-3219  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug 23 1909  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Avalon Manor Home, Inc.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>19 E. Baltimore Street  |  |   |  |
| 10f. ZIP CODE<br>21740  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown 0  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Her own home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Washington Armstrong  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora Blanche Myers   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harold Clark  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>916 Chestnut Street Hagerstown, Maryland 21740   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Cemetery 4-13-96 Smithsburg, Maryland  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Scott M. Minnich   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Md. 21740   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>1 yr  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Auto intensive bleeding diathesis   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Vasant Datta   |  |  |  | 29c. LICENSE NUMBER<br>D18019   |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 10, 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Vasant Datta 334 Mill Street Hagerstown, Maryland 21740  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 11 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Anderson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12409

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AUDREY PAULINE SLEAMAN

2. Date of Death

Month  
APRIL

Day

11- Year  
1996

3. Time of Death

4:00P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CHINTON

4c. County of Death

PRINCE GEORGE

5. Social Security Number

217-16-6268

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
OCT. 17, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

BRANDYWINE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10505 CEDARVILLE ROAD, #41

10f. Zip Code

20613

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM JACOB LITTLE

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANGELA CONWAY

19a. Informant's Name/Relationship (Type, Print)

SUSAN SHANK - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3028 BRAMBLEWOOD COURT, WALDORF, MARYLAND 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERANS CEM. APRIL 16, 1996 CHELTENHAM, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MGB BENJAMIN M. MATTHEWS MO0658

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.  
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac shock

Due to (or as a consequence of):

b. Pulmonary embolism

Due to (or as a consequence of):

c. Cardiac arrhythmia

Due to (or as a consequence of):

d. CAD

Approximate Interval Between Onset and Death  
5 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM  
Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. G.

29c. License number

D24208

29d. Date signed (Month, Day, Year)

4.11.96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABULHASAN U ANSARI MD Attending PMD Clinton Md 20735

State  
Registrar

31. Date filed (Month, Day, Year)

04 APR 16 1996

32. Registrar's Signature

Julia Anderson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





96 12410

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |  |  |   |  |  |  |
|--|--|--|---|---|---|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARGARET ROMAINE SEITZ   |  |  |   | 2. DATE OF DEATH<br>MONTH 4 DAY 11 YEAR 96  |   |  |  | 3. TIME OF DEATH<br>1:48 p.m.   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-32-8579   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>85 YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 6, 1910 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Longview Nursing Home  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Manchester   |   |  |  | 9c. COUNTY OF DEATH<br>Carroll  |  |  |  |
| 10a. STATE<br>Maryland   |  |  |   | 10b. COUNTY<br>Carroll  |   | 10c. CITY, TOWN OR LOCATION<br>Westminster   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>807 William Avenue   |  |  |   | 10f. ZIP CODE<br>21157  |   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Education   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Stem Barnes  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lena Grace Pickett   |   |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>C. Douglass Seitz  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1600 Miller Road, Westminster, MD 21158  |   |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Carroll Crematory   |   | DATE<br>4/12  |   | 20c. LOCATION — City or Town, State<br>Hampstead, Maryland                           |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert A. Myers</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Myers Funeral Home<br>91 Willis Street, Westminster, MD 21157   |   |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Dementia</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |   |   |   |  |  | Approximate Interval Between Onset and Death<br>Years   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |   |   |   |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |   |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |   |   |   | 29c. LICENSE NUMBER<br>253165  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/11/96  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stearns &amp; Foster Inc. 2114 Union Pk. (Annapolis) Md 21074</i>  |  |  |   |   |   |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 12 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |   |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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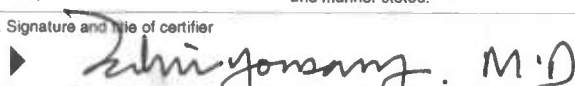
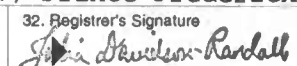
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12411

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |   |                                   |
|---|---|--|---|--|---|--|--|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Charles ANTHONY Schertle, Sr.</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>11</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2330</b>  |   |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  | 4c. County of Death<br><b>Calvert</b>  |   |                                   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-20-2453</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>2-2-1927</b>                           |   |                                   |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CALVERT</b>   |  | 10c. City, Town or Location<br><b>LUSBY</b>                                      |   |                                   |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>431 STALLION LANE</b>  |  | 10f. Zip Code<br><b>20657-2569</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |   |                                   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |   |                                   |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INSURANCE AGENT</b>   |  | 16b. Kind of Business/Industry<br><b>OWNER INSURANCE AGENCY</b>   |  |  |   |                                   |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN SCHERTLE</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA BROCKMEYER</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLOTTE P. SCHERTLE</b>  |  |  |   |                                   |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS #10</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD.VETERANS CEM. 4-16-96</b>   |  | 20c. Location - City or Town, State<br><b>CHELTENHAM, MARYLAND</b>               |   |                                   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL HOME<br/>DUNKIRK, MARYLAND 20754</b>   |  |   |  |  |   |                                   |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic Renal failure</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Malignant lymphoma.</b><br>Due to (or as a consequence of):<br><br><b>c. COPD.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                                   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                                   |
|   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D27189</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/12/96.</b>  |  |  |   |                                   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Zahir Yousaf, M.D., Prince Frederick, MD. 20678</b>  |  |   |  |   |  |  |   |                                   |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1996</b>   |  | 32. Registrar's Signature<br>  |  |   |  |  |   |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12412

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA BURNS STEVENS

2. Date of Death

Month Day Year  
APRIL 7, 1996

3. Time of Death

6:40pm

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

212-38-7650

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1909

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Va.

10b. County

Fairfax

10c. City, Town or Location

Herndon

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1223 Shaker Dr.

10f. Zip Code

22070

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

public schools

17. Father's Name (First, Middle, Last)

Jacob Leo Burns

18. Mother's Name (First, Middle, Maiden Surname)

Daisy McCollum

19a. Informant's Name/Relationship (Type, Print)

Edith Jackson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1223 Shaker Dr., Herndon, Va. 22070

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Reformed Cemetery

Date

4/10

20c. Location - City or Town, State

Middletown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

31 E. Main St., Middletown, Md. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. Acute Respiratory Failure  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Cor Pulmonale  
Due to (or as a consequence of):c. Idiopathic Pulmonary Fibrosis  
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D12015

29d. Date signed (Month, Day, Year)

4/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Steinberg MD 6492 Landover Rd Landover, Md

31. Date filed (Month, Day, Year)

APR 10 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



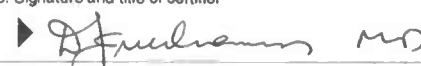
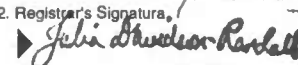
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12413

|  |  |   |   |  |  |   |   |  |
|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EVA MATILDA STEEGER</b>   |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>4</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>6:19pm</b>                                       |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |   | 4c. County of Death<br><b>MONTGOMERY</b>                                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>208-16-0319</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 1 1927</b>                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Boyd's</b>                            |  |
| To Be Completed by<br>Funeral Director   | Usual Residence of Decedent  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
|  | 10a. Street and Number<br><b>21610 Slidell Rd</b>  |   |   |  | 10f. Zip Code<br><b>20841</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crossing Guard</b>                |  | 16b. Kind of Business/Industry<br><b>Montg. Co. Schools</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles E. Barr</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Jane Asher</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lisa Joyce Lamb daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21610 Slidell Rd. Boyd's, Md 20841</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn</b>   |  | 20c. Location - City or Town, State<br><b>4/9/96 Rockville, MD</b>   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Hilton Funeral Home<br/>Barnesville, MD 20838</b>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Arrest</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Conestive heart failure / diabetes</b> |   |   |  | Approximate interval Between Onset and Death<br><b>Immediate</b><br><b>10 years</b>  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Conestive heart failure / diabetes</b>  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   | 29b. Signature and title of certifier<br><br><b>MD</b>          |  | 29c. License number<br><b>P 24971</b>   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>April 5, 1996</b>  |  |   |   |  |  |   |   |  |
| 30. Name and address of person who completed causa of death (item 23a) (Type, Print)<br><b>15225 SMOY GROVE Rd Rockville MD 20850</b>  |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1996</b>  |  | 32. Registrar's Signature<br><br><b>Julia Davidson</b>   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner





96 12414

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Norman JACOB Shriver</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>4</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>8:15 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-12-2934</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 4, 1907</b>                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9. COUNTY OF DEATH<br><b>FREDERICK</b>  |  |  |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>ST. CATHERINE'S NURSING CENTER</b>   |  |  |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>EMMITSBURG</b>  |  | 12. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 13. STATE<br><b>MARYLAND</b>  |  | 14. COUNTY<br><b>FREDERICK</b>   |  | 15. CITY, TOWN OR LOCATION<br><b>EMMITSBURG</b>   |  | 16. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 17. STREET AND NUMBER<br><b>16656 TOM'S CREEK CHURCH RD.</b>  |  |  |  | 18. ZIP CODE<br><b>21727</b>  |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 20. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 23. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 24. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>COLLEGE 4</b>  |  | 25. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARMER &amp; CATTLE DEALER</b>  |  | 26. KIND OF BUSINESS/INDUSTRY<br><b>CATTLE DEALER</b>   |  |  |  |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>ERNEST R. SHRIVER</b>   |  |  |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HARRIET MAE WAYBRIGHT</b>   |  |  |  |
| 29. INFORMANT'S NAME (Type/Print)<br><b>EDITH SHRIVER</b>   |  |  |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16656 TOM'S CREEK CHURCH RD., EMMITSBURG, MD. 21727</b>                                      |  |  |  |
| 31. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>EVERGREEN CEMETERY</b>  |  | 33. DATE<br><b>4/4/96</b>   |  | 34. LOCATION — City or Town, State<br><b>GETTYSBURG, PA. 17325</b>                             |  |
| 35. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John M. Skiles</b>  |  |  |  | 36. NAME AND ADDRESS OF FACILITY<br><b>SKILES FUNERAL HOME<br/>210 W. MAIN ST., EMMITSBURG, MD. 21727</b>   |  |  |  |
| 37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>atrial fibrillation</b><br>b. <b>CHF</b><br>c. <b>C.A.D.</b><br>d. <b>CVA</b> |  |  |  |   |  |  |  |
| 38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>emphysema</b><br><b>dementia</b>   |  |  |  |   |  |  |  |
| 39. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 41. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  | 42. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 43. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 44. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 45. DATE OF INJURY (Month, Day, Year)<br><b>4/4/96</b>  |  | 46. TIME OF INJURY<br><b>M</b>   |  |
| 47. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 48. DESCRIBE HOW INJURY OCCURRED   |  | 49. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)  |  | 50. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 51. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 52. SIGNATURE AND TITLE OF CERTIFIER<br><b>C. Curley MD</b>   |  |  |  | 53. LICENSE NUMBER<br><b>D39937</b>   |  | 54. DATE, SIGNED (Month, Day, Year)<br><b>4/4/96</b>   |  |
| 55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Christine Curley MD, 302 W. Main, Emmitsburg MD</b>   |  |  |  |   |  |  |  |
| 56. DATE FILED (Month, Day, Year)<br><b>APR 9 1996</b>  |  | 57. REGISTRAR'S SIGNATURE<br><b>John A. Raskin</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12415

## Certificate of Death

Reg. No.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Evelyn Steingart  |   | 2. Date of Death<br>Month Day Year<br>April 1 1996  |   | 3. Time of Death<br>1:15 AM   |
|  | 4a. Facility Name (If not institution, give street and number)<br>FREDERICK MEMORIAL HOSPITAL   |   | 4b. City, Town, or Location of Death<br>FREDERICK   |   | 4c. County of Death<br>FREDERICK  |
| Funeral<br>Director  | 5. Social Security Number<br>577-07-5369  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>83 Yrs.   | If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br>2-25-13  |   | 9. Birthplace (State or Foreign Country)<br>NEW JERSEY  |   |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |   |   |   |
|  | 10e. State<br>MD.   | 10b. County<br>FREDERICK  | 10c. City, Town or Location<br>THURMONT   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br>10617 POWELL RD.  |   | 10f. Zip Code<br>21788  |   | 10g. Citizen of What Country?<br>United States  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker     |   | 16b. Kind of Business/Industry<br>own home  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br>Morris Leon  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Sadie Gordon   |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Marsha Abernethy (daughter)   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10617 Powell Rd./ Thurmont, Maryland 21788           |   |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mount Sharon Cemetery   |   | 20c. Location - City or Town, State<br>4-3-96 Springfield, Pa.  |
|  | 21. Signature of Funeral Service Licensee<br>Raymond Peterson   |   | 22. Name and Address of Facility<br>STAUFRER F.H. 1621 OPOSSUMTOWN PIKE FREDERICK, MD. 21701  |   |   |
|  | Physician<br>/Medical<br>Examiner   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>arterio sclerotic cardiovascular disease</u><br>Due to (or as a consequence of):<br>b. <u>DM</u> <u>diabetes mellitus</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |   |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                      |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |   |
| 29b. Signature and title of certifier<br>Mickum  |   | 29c. License number<br>DI 5804  |   | 29d. Date signed (Month, Day, Year)<br>4-1-96 |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEVEN PICKERT JR 100 S Center ST Thurmont MD 21788  |   |   |   |   |   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>APR 04 1996  |   | 32. Registrar's Signature<br>John Sullivan  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

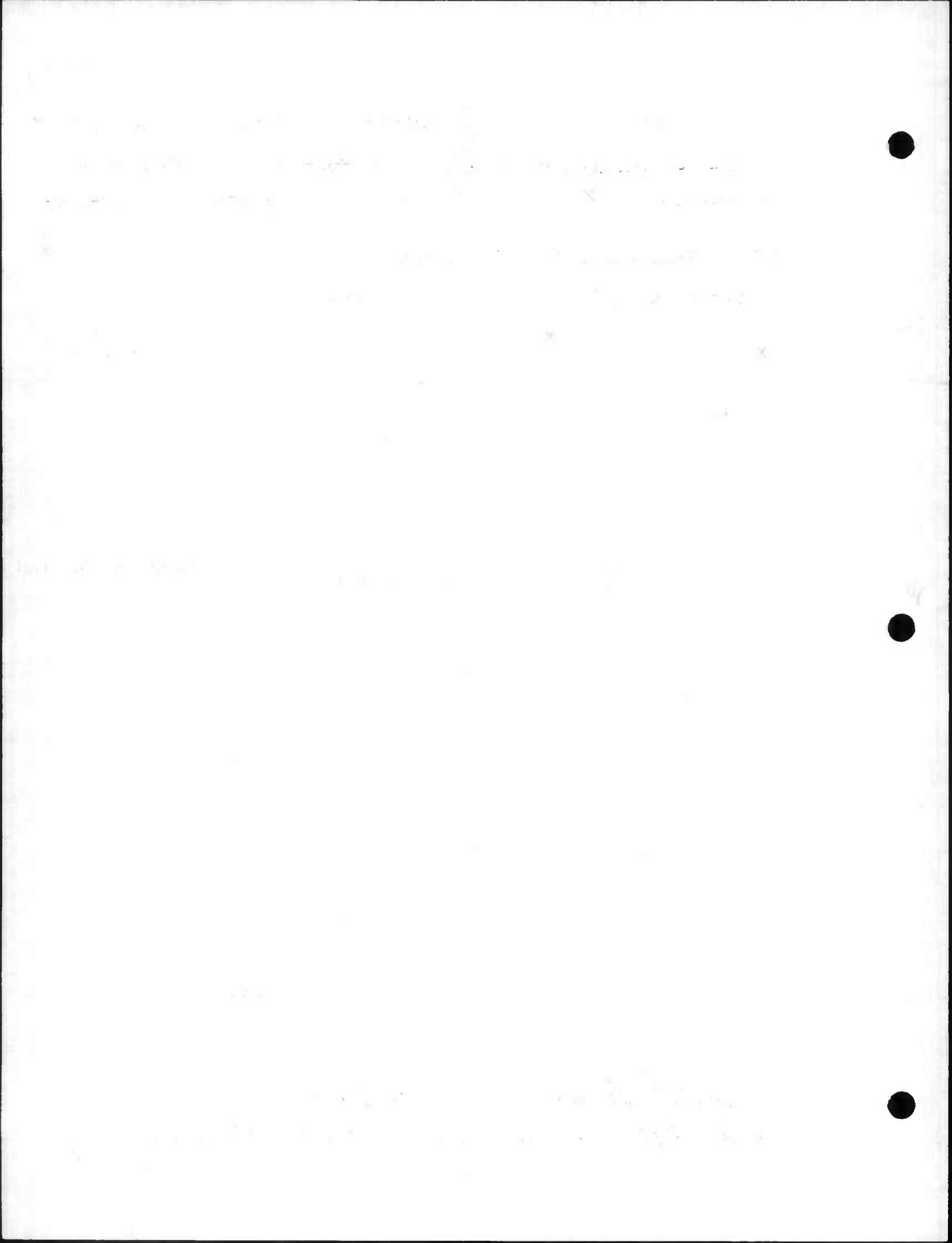
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12416

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Amelia SMITH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>30</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>4:30 pm M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-50-7723</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb 28, 1918</b>                                       |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>136 West Hammaker Street</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Thurmont</b>  |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Thurmont</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>136 Hammaker Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21788</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marion Grayson FEAGA</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hallie May CUTSAIL</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Elton H. Smith (Husband)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>136 W Hammaker Street, Thurmont, Maryland 21788</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Resthaven Mem Gar Apr 3, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John L. Hansen</i> MO0706  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home<br/>106 East Church Street, Frederick MD 21701</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Breast</b>   |  |  |  |   |  |   | <b>Months</b>   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |   |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify)   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b>1</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James L. Krantz</i> M.D.   |  |  |  | 29c. LICENSE NUMBER<br><b>D35152</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 1, 1996</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James L. Krantz, M.D., 180 Thomas Johnson Dr, #101, Frederick, Maryland 21702</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Victor Strassberger, Jr.</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28, 1996</b>  |  | 3. TIME OF DEATH<br><b>4:45 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-42-6660</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>26816 Howard Chapel Drive</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Damascus</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Damascus</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>26816 Howard Chapel Drive</b>   |  | 10f. ZIP CODE<br><b>20872</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+) <b>3 College</b>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Auditor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>William V. Strassberger, Sr.</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Brennan</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Angela G. Strassberger</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26816 Howard Chapel Drive, Damascus, Maryland 20872</b>   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium</b>   |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert L. Williams</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A.<br/>26401 Ridge Rd., Damascus, Md. 20872</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Esophageal Cancer</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>March 28, 1996</b>   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John M. Williams, MD</b>   |  | 29c. LICENSE NUMBER<br><b>033686</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 29, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John M. Williams, MD</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John M. Williams, MD</b>  |  |

1944-45

1945-46

1946-47

1947-48

1948-49

1949-50

1950-51

1951-52



96 12418

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ida Grace STUP</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28, 1996</b>  |  | 3. TIME OF DEATH<br><b>6:10 am</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-10-0089</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>101</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 10, 1894</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Health Care Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1720 North Market Street</b>  |  |
| 10f. ZIP CODE<br><b>21701</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lemual BABINGTON</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha MOSS</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Veronica I. Hahn, Daughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>610 Mary Street, Frederick, Maryland 21701</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Mount Olivet Cemetery, April 1, 1996</b>  |  | 20c. LOCATION — City or Town, State<br><b>Frederick, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Richard E. Truf</b> M00255  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home<br/>106 E Church Street, Frederick, MD 21701</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>MI</b><br>c. <b>Fracture Left Femur</b><br>d. <b>25yrs.</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fracture Left Femur</b>  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>March 18, 1996</b>   |  | 28b. TIME OF INJURY<br><b>2:5</b> M  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>Fall</b>   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1720 N. Market St. Frederick MD 21701</b>   |  |  |  |
| 29a. CERTIFIER<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Arthur G. Manalo, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18191</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 28, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arthur G. Manalo, M.D., 187 Thomas Johnson Drive, #3, Frederick, Maryland 21702</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 01 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>James Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Medical Examiner not notified - name of death is furnished.

100

96 12419

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Yadgi SOLLOD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>28</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>12:30am</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-05-7341</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec 17, 1912</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Syria</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sunrise Retirement Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  |   |  |
| 10b. COUNTY<br><b>Frederick</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>990 Waterford Drive</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21702</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Pharmacy</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Saba</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sophia MASTRY</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Judith A. Ricketts</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 339, Braddock Heights, Maryland 21714</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery Mar 29, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, D.C., NE</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen Robinson</i> <b>MO0706</b>                               |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church St. Frederick, MD 21701</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>Alzheimer's Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Retirement Home</b>  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kevin Hohl, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D43780</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>March 28, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kevin Hohl, M.D., 300 South Church Street, Middletown, Maryland 21769</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 29 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>James Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located in the center of the page.

96 12420

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Mildred SOUTHERLAND   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 26, 1996  |  | 3. TIME OF DEATH<br>8:50 A. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>556-12-4679   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>87 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 22, 1909  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Arkansas  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1596 Abbey Court   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  | 9c. COUNTY OF DEATH<br>Frederick  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |   | 10c. CITY, TOWN OR LOCATION<br>Frederick  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6229 White Oak Drive   |  |  |   | 10f. ZIP CODE<br>21701  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>School Teacher  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Education   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert LEWIS  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Jennie MALONE  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Robert L. Rogers   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6229 White Oak Drive, Frederick, MD 21701  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holders Cemetery, April 2, 1996   |   | 20c. LOCATION — City or Town, State<br>Bay Springs, Mississippi   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Allan H. Ruby MO0703  |  | 22. NAME AND ADDRESS OF FACILITY<br>Keeney & Basford P.A. Funeral Home<br>106 East Church St., Frederick, MD 21701   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiovascular heart failure</i>   |  |  |   |   |  |   |  |
| Due TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |   |   |  |   |  |
| b. Due TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |  |   |  |
| c. Due TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |  |   |  |
| d. Due TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Robert S. Hughes  |  |  |   | 29c. LICENSE NUMBER<br>D05111   |  | 29d. DATE SIGNED (Month, Day, Year)<br>March 26, 1996   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Robert S. Hughes, M.D., 700 Montclair Avenue, Frederick, MD 21701   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 28 1996   |  | 32. REGISTRAR'S SIGNATURE<br>J. Davidson-Randall   |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12421

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIE W STANCIL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>2</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>3-13 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>246-40-5465</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 22, 1932</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NORTH CAROLINA</b>  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LAUREL</b>   |  |
| 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CAPITOL HEIGHTS</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>6029 APPLEGRATH PLACE</b>   |  |
| 10f. ZIP CODE<br><b>20743</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>NOV. 1950 to NOV. 1955</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>N/A</b>  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12TH</b>   |  |  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FOREMAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRIVATE</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>STEVEN STANCIL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOLA POWELL</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>NORA L. STANCIL (WIFE)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6029 APPLEGRATH PL., CAPITOL HEIGHTS, MD 20743</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GLENWOOD CEMETERY APRIL 6, 1996 WASHINGTON, D.C.</b>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edward M. Dudley</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDLEY FUNERAL HOME<br/>3200 RHODE ISLAND AVE., MT. RAINIER, MD</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia</b>  |  |  |  |   |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes mellitus</b>   |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>hypertension</b>  |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CVA</b>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Pritham Sol</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D28998</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-2-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PRITHAM SOL MD 9101 Cherry Ln #211<br/>Laurel MD 20708</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 03 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-2001 2001-2002



96 12422

i  
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM A. SEALES Sr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 1 1996</b>   |  | 3. TIME OF DEATH<br><b>2:05 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>426-76-2259</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6/13/37</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1812 Arcola Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1812 Arcola Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>20902</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>None</b><br>College (1-4 or 5+) <b>None</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>None (Disabled)</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ben Seales</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eular Johnson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William A. Seales Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1500 Savannah St SE, #113, DC 20032</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>  |  | DATE<br><b>4/6/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, DC</b>                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Philip J. Kay</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T. Rhines Co., Inc.<br/>3030 12th St NE, DC 20017</b>   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>IDIOPATHIC CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEART FAILURE</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul J. Woronow</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>23805</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 1, 1996</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR DANIEL WORONOW<br/>344 UNIVERSITY BLVD W #213. SILVER SPRING MD 20901</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John T. Rhines</i>  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

admission 1882 80

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12423

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |   |  |  |  |
|--|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS SPRIGGS</b>   |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>03</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>12:30 AM</b>                        |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHEAST MARYLAND HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>               |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-24-4306</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>02-09-21</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Suitland</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>4876 Eastern Lane #201</b>   |   |   |  | 10f. Zip Code<br><b>20746</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>                     |  |  | 16b. Kind of Business/Industry<br><b>Private</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Diggs</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jaine Spriggs</b>  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonita Spriggs/Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2258 Maple Ridge #102, Landover, MD 20785</b>  |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | Date<br><b>4/13</b>  |   | 20c. Location - City or Town, State<br><b>Landover, MD</b> |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Humfrey Buscietonic</b>   |   |   |  | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home</b><br><b>7474 Landover Road, Landover, MD 20785</b>   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><b>HYPERTENSIVE HEART DISEASE</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>FEW YRS</b><br><b>MANY Yr</b> |   |   |  |  |   |  |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION</b>   |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury<br>(Month, Day Year)                  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Attending</b> |   | 29c. License number<br><b>D-44436</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>4-4-96</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A SHIVKUMAR J PATEL, 603 1st St #207, WILMINGTON MD 20602</b>   |   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1996</b>  |   | 32. Registrar's Signature<br><b>John Andrew Randall</b>   |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12424

## Certificate of Death

Reg. No.

|  |  |                                       |   |   |  |   |  |   |
|--|--|---------------------------------------|---|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS STEWART</b>  |                                       |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>06</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>0100 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL E.R.</b>   |                                       |   |   | 4b. City, Town, or Location of Death<br><b>LAUREL</b>  |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-74-2021</b>  |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day, Year)<br><b>05-23-58</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent  |                                       |   |   |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Prince George's</b> |   | 10c. City, Town or Location<br><b>Landover</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>4066 Warner Avenue</b>  |                                       |   | 10f. Zip Code<br><b>20784</b>   |  | 10g. Citizen of What Country?<br><b>USA</b> |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1+</b>  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Operator</b> |  |   | 16b. Kind of Business/Industry<br><b>Private</b>   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Stewart</b>   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Rawlings</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Hilton/Mother</b>   |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4066 Warner Avenue, Landover, MD 20784</b>   |   |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veteran's</b>   |   | Data<br><b>4/12/96</b>   |   | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>                                   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Spencer C. Briscoe-Tonic</i>   |                                       |   |   | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, MD 20785</b>   |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Stab Wound of Neck</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                       |   |   |  |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                       |   |   |  |   |  |   |
| State Registrar  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                       |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide   |                                       | 28a. Date of Injury (Month, Day, Year)<br><b>4-5-96</b>   |   | 28b. Time of Injury<br><b>1215 A M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  | 28d. Describe how injury occurred<br><b>subject stabbed</b>  |                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1308 Laurel Bowie Rd<br/>Laurel, Md</b>                        |   |  |   |  |   |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                       |   |   |  |   |  |   |
|  | 29b. Signature and title of certifier<br><i>Dennis J. Chute MD</i>   |                                       |   |   | 29c. License number<br><b>O.C.M.E</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 6, 1996</b>                                    |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b> |  |                                       |   |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1996</b>  |  |                                       |   | 32. Registrar's Signature<br><i>J. A. Anderson-Randall</i>  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

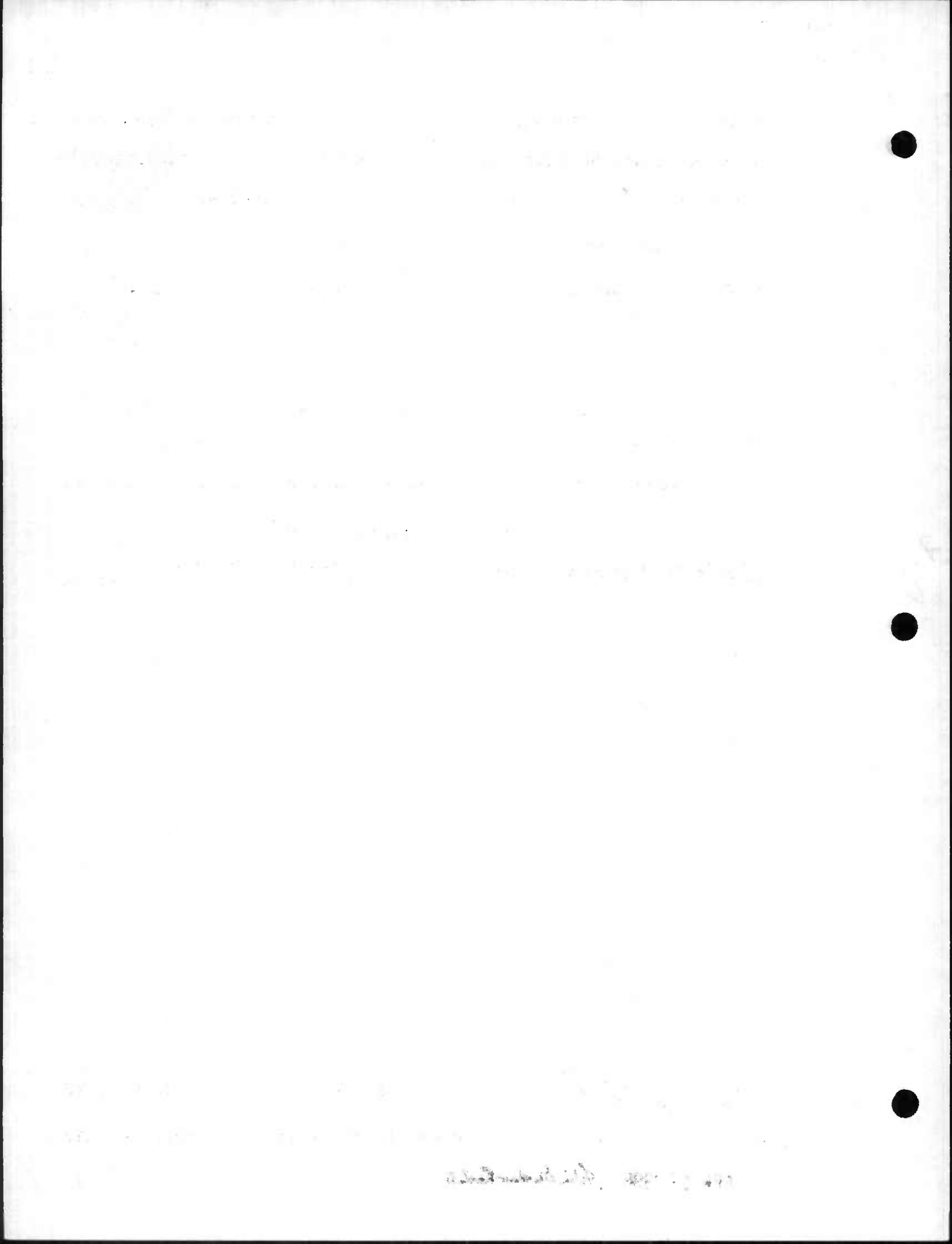
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12425

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOUGLAS

2. Date of Death

Month

Day

Year

April 8 1996

3. Time of Death

7:30 AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

4202 58 th Ave.

4b. City, Town, or Location of Death

Bladensburg Md.

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

249424062

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
6/15/30

9. Birthplace (State or Foreign Country)

Clinton SC.

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4202 58th Ave.

10f. Zip Code

20710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Govt. Worker

16b. Kind of Business/Industry

Govt.

17. Father's Name (First, Middle, Last)

Jessie Suber

18. Mother's Name (First, Middle, Maiden Surname)

Ada Byrd Tate

19a. Informant's Name/Relationship (Type, Print)

Donward Suber

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7700 Livingston Rd. Oxon Hill Md.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park

Date

4/13/96

20c. Location - City or Town, State

Landover Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1425 Maryland Ave, N. E., Hoffman Funeral Service

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Seconds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be determined ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D25925

29d. Date signed (Month, Day, Year)

April 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda Md 20814

31. Date filed (Month, Day, Year)

APR 11 1996

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*Journal of Management Studies*, 2006; 43(7): 989–1004



96 12426

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James M. Stuart   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 9, 1996   |  |  |  | 3. TIME OF DEATH<br>7:06PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>013-22-6866  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>65 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-23-31                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br>Massachusetts   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Ft. Washington Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Fort Washington  |  |  |  | 9c. COUNTY OF DEATH<br>Prince George  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Prince George's  |  | 10c. CITY, TOWN OR LOCATION<br>Oxon Hill  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>405 Barrymore Drive   |  |   |  | 10f. ZIP CODE<br>20745  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1949 to 1969   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>2 years  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Senior Master Sgt.   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Air Force  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gerald B. Stuart   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Clara M. MacKenzie   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lois A. Stuart  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>405 Barrymore Dr. Oxon Hill, Maryland 20745  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veteran's Cem. 4-12-96  |  | 20c. LOCATION — City or Town, State<br>Cheltenham, Maryland   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Cervical Artery<br>Neurovascular Carcinoma<br>Empty Stomach<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>30 min<br>4 hrs<br>20 hrs   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Timothy C. Bayly, M.D.   |  | 29c. LICENSE NUMBER<br>D18689   |  | 29d. DATE SIGNED (Month, Day, Year)<br>15 April 1996                                 |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Timothy C. Bayly, M.D. 5510 Alma Ln. Springfield, Virginia 22151   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 11 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/11/10

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marie A. Turner</b>   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 29, 1996</b>  |   | 3. TIME OF DEATH<br><b>9:36 AM</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>158 26 2970</b>  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 15, 1936</b> | 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bowie Health Center</b>   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bowie</b>   |   | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |
| RESIDENCE OF DECEDENT  |   |   |   |   |
| 10a. STATE<br><b>Maryland</b>  | 10b. COUNTY<br><b>Prince George's</b>   | 10c. CITY, TOWN OR LOCATION<br><b>Bowie</b>   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |
| 10e. STREET AND NUMBER<br><b>3004 Savoy Lane</b>   |   | 10f. ZIP CODE<br><b>20715</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b> | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>No</b>   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Fiscal Clerk</b>   |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State Of Maryland</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Christopher Wilson</b>   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Goodneck</b>  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Turner</b>  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3004 Savoy Lane Bowie Maryland 20715</b>  |   |   |
| 20a. MANNER OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 3/4/96</b>   |   | 20c. LOCATION — City or Town, State<br><b>Alexandria Virginia</b>   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert E. Evans, Pres.</b>   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert E. Evans Funeral Home, P.A.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASCHD</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac arrest.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |   |   |   | Approximate Interval Between Onset and Death<br><b>—</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>   |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |   | 28a. DATE OF INJURY (Month, Day, Year)  | 28b. TIME OF INJURY<br><b>M</b>                             | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. DESCRIBE HOW INJURY OCCURRED   |   |   |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |   | 29c. LICENSE NUMBER<br><b>D35820</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/1/96</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter Eckberg MD 14200 Gallant Fox Lane #110 Bowie, MD 20715</b>   |   |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 05 1996</b>  |   | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CS/ 5

RECEIVED MAR 20 1950

96 12428

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |   |  |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY LOUISE TRIPLETT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Apr</b> DAY <b>14</b> YEAR <b>1996</b>   |  |  |   | 3. TIME OF DEATH<br><b>3:30 a m</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-80-1491</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 12, 1924</b>                                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>WV</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CUMBERLAND NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  |  |   | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |   | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>12914 N Cresap St Apt 37</b>   |  |  |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Keyser Courthouse</b> |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Fred Harrison Alt</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virgie (Borror)</b>   |  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Suzie Triplett</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12920 N. Cresap Street; Cumberland, MD 21502</b>  |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment)<br><b>Rocky Gap Veterans Cem</b>   |  | DATE<br><b>04/17</b>  |  | 20c. LOCATION — City or Town, State<br><b>Flintstone, MD</b>                                       |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James J. Scarpelli</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>C.A.D.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Diabetes mellitus</b> |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>10 yrs.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>8</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William D. Lamm</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D25406</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 17, 1996</b>                                       |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William D. Lamm M.D., 47 Virginia Avenue; Cumberland, MD 21502</b>  |  |  |  |   |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 18 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jodi Dawson-Randall</i>  |  |   |  |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 12429**  
Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |   |   |
|--|--|---|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE E. TARQUIN</b>  |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>15</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>5:55 AM</b>                                      |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  | 4c. County of Death<br><b>ALLEGANY</b>                                  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>301-22-9218</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 30, 1916</b>              | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |
|  | Usual Residence of Decedent  |   |   |  |  |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>  | 10b. County<br><b>Richland Twnship</b>  | 10c. City, Town or Location<br><b>Johnstown</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |
|  | 10e. Street and Number<br><b>343 Theatre Drive</b>   |   |   | 10f. Zip Code<br><b>15904</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b>   |   | Collage (1-4or 5+)<br><b>Homemaker</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles B. Speicher</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Mussetta (Lightner)</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Saundra Banker</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Route 1 Box 50; Salisbury, PA 15558</b>  |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Grandview Cemetery</b>   |  | Data<br><b>04/19</b>   |  | 20c. Location - City or Town, State<br><b>Johnstown, PA</b>             |   |
|  | 21. Signature of Funeral Service Licensee<br><b>James F. Scarpelli</b>   |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home for Geisel FH<br/>Cumberland, MD 21502</b>   |  |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   | Approximate Interval Between Onset and Death  |
|  | a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>LYMPHANGITIC CARCINOMA OF LUNG</b><br>Due to (or as a consequence of):<br>c. <b>METASTATIC CARCINOMA OF THE BREAST</b><br>Due to (or as a consequence of):<br>d.  |   |   |  |  |  |   | <b>36 HOURS</b><br><br><br><b>unknown</b><br><br><b>unknown</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>S. Changm D.</b>  |   | 29c. License number<br><b>D-25638</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 16, 1996</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SATURNINA CHANGM.D. RT 36 FROSTBURG, PLAZA FROSTBURG Maryland 21532</b>   |  |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 18 1996</b>  |  | 32. Registrar's Signature<br><b>John Davidson Rector</b>  |   |  |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





VOID

CERTIFICATE #

96 12430

SEE

CERTIFICATE #

96 12429



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12431

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Luther Solomon THOMAS, Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

April

11

1996

2017

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

216-14-5265

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 23, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19007 Manor Church Rd.

10f. Zip Code

21713

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Joseph Luther Solomon Thomas, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Susan Frances Kephart

19a. Informant's Name/Relationship (Type, Print)

Mary J. Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19007 Manor Church Rd. Boonsboro, MD 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenlawn Mem. Park April 13, 1996

Date

20c. Location - City or Town, State

Williamsport, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home  
425 S. Conococheague St. Williamsport, MD 2179523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. probable myocardial infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

30 minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. atherosclerotic disease  
Due to (or as a consequence of):

year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide 6 ☐ Could not be28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D32518

29d. Date signed (Month, Day, Year)

4-13-96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr Guedenet 100 Greeting Lane Keedysville md

31. Date filed (Month, Day, Year)

APR 15 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



96 12432

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MELVIN T. TUGGLE, SR.  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 9, 1996   |  | 3. TIME OF DEATH<br>2:10 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>223-46-7140   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>61 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>OCT. 8, 1934  |  |
| 8. FACILITY NAME (If not Institution, give street and number)<br>44 MAPLE COURT  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ELKTON   |  | 9c. COUNTY OF DEATH<br>CECIL COUNTY   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>CECIL COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>ELKTON   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>44 MAPLE COURT   |  |   |  | 10f. ZIP CODE<br>21921  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CARPENTER/J&B BUILDERS   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>CARPENTRY/BUILDER   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GRAHAM TUGGLE   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SUSIE WHITE  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARGARET H. TUGGLE   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>44 MAPLE COURT, ELKTON, MARYLAND 21921   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br>KEMBLESVILLE CEMETERY 4/12/96   |  | 20c. LOCATION — City or Town, State<br>KEMBLESVILLE, PA   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT T. JONES & FOARD, INC.<br>122 WEST MAIN ST., NEWARK, DE 19711  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Emphysema</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br>C1001683   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/10/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>10-88 OMBA RR, Newark, Del 19713  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 12 1996   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12434

## Certificate of Death

Reg. No.

|   |  |                                |   |  |   |  |   |  |   |  |
|---|--|--------------------------------|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MINDY DAWN VANPELT</b>                  |                                |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 26, 1996</b> |  | 3. Time of Death<br><b>12:35 P</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>RT. 220 NORTH</b> |                                |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rawlings</b>     |  | 4c. County of Death<br><b>ALLEGANY</b>                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-11-0411</b>  |                                | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>17</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 18 1979</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |                                |   |  |   |  |   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Allegany</b> |   | 10c. City, Town or Location<br><b>Rawlings</b>   |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>21810 McMullen Highway N.W.</b>  |  |                                |   |  |   | 10f. Zip Code<br><b>21557</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)   |  |                                |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>  |   |  | 16b. Kind of Business/Industry<br><b>High School</b>        |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Nathan VanPelt</b>  |  |                                |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vicki Miller</b>   |   |  |   |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Mr. &amp; Mrs. Nathan VanPelt Parents</b>  |  |                                |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21810 McMullen Highway N.W. Rawlings, MD 21557</b> |   |  |   |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dawson Cemetery March 30 1996</b>   |   | 20c. Location - City or Town, State<br><b>Rawlings, MD 21557</b>   |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                |   |  |   | 22. Name and Address of Facility<br><b>Rotruck-Smith Funeral Home<br/>85 South Main Street Keyser, WV 26726</b>  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>MULTIPLE TRAUMES</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |   |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>INSTANTLY</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |  |                                |   |  |   |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
|   |  |                                |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>MVA</b> |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                                |   | 28a. Date of Injury (Month, Day Year)<br><b>3 26 96</b>  |   | 28b. Time of Injury<br><b>12:17 PM</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  |                                |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>ROADWAY</b>   |   | 28d. Describe how injury occurred<br><b>ANOTHER CAR DRIVEN OFF ROAD IN COLLISION WITH</b>  |   |  |   |  |
|   |  |                                |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>RT 220 NORTH ALLEGANY CO MD</b>   |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Hospital Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                |   | 29b. Signature and title of certifier<br><br><b>Mandy D. Kozlov</b>   |   | 29c. License number<br><b>OCME</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 27, 1996</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARYANN D. Kozlov MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |                                |   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 04 1996</b>   |  |                                |   | 32. Registrar's Signature<br>   |   |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. The first part of the report is devoted to a general description of the project and its objectives. It is followed by a brief review of the literature on the subject.

2. The second part of the report describes the methodology used in the study. This includes a detailed account of the data collection process and the statistical methods employed for data analysis.

3. The third part of the report presents the results of the study. These are discussed in the context of the research objectives and the existing literature.

4. The fourth part of the report discusses the implications of the findings for practice and policy. It also identifies some of the limitations of the study and suggests areas for future research.

5. The final part of the report is a conclusion that summarizes the main findings and the overall contribution of the study to the field.



96 12433

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elmer Huntt Tippet, Sr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>04 05 1996   |  | 3. TIME OF DEATH<br>2:15 P. M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>218-05-7104  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 28, 1919  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>9606 Old Allentown Rd.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Ft. Washington  |   |
| 9c. COUNTY OF DEATH<br>Prince George's  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |   |
| 10c. CITY, TOWN OR LOCATION<br>Ft. Washington   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>9606 Old Allentown Road  |   |
| 10f. ZIP CODE<br>20744  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Property Officer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>D.C. Gov't. Police Dept.   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Hammond Tippet  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Clara Aliene Cooke  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>C. Shirley Thorne Tippet  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9606 Old Allentown Rd. Ft. Washington, Md. 20744  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery 4/9/96  |  | 20c. LOCATION — City or Town, State<br>Suitland, Maryland  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George P. Kalas</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |  |   |
| 23. PART I. Enter the illnesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Chronic obstructive pulmonary disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>10 yrs</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY M  |   |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William T. Oetgen, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D-16129   |  | 29d. DATE SIGNED (Month, Day, Year)<br>04-05-96  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>William T. Oetgen, MD 9131 Piscataway Rd #600 Clinton, MD 20735</i>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>APR 08 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

511 101 101 101 101

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12435

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |   |  |  |
|--|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEWIS LEE VANMETER</b>   |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>16</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>15:20</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |   | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-04-9396</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>27</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 31, 1968</b>   | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>MD</b>   |   | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Rawlings</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>P.O. Box 113</b>   |   |   |  | 10f. Zip Code<br><b>21557</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Persian Gulf</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Corrections Officer</b>  |   | 16b. Kind of Business/Industry<br><b>Roxbury Correctional Inst</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Melvin L. VanMeter</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara J. (Smith)</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna VanMeter--wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 113; Rawlings, MD 21557</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Biertown Cemetery</b>  |  | Data<br><b>04/19</b>   |   | 20c. Location - City or Town, State<br><b>Rawlings, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>James F. Scarpelli</b>  |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |   |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. Diffuse Alveolar Lung Damage</b><br>Due to (or as a consequence of):<br><b>b. Toxic reaction to chemotherapy</b><br>Due to (or as a consequence of):<br><b>c. Hodgkins Lymphoma</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |  | Approximate Interval Between Onset and Death<br><b>6 weeks</b><br><b>6 weeks</b><br><b>2 years</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |   | 29b. Signature and Title of Certifier<br><b>Thomas Evan Chapell MD</b>  |   |  |  |   |  |  |
| 29c. License number<br><b>MD 35135</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 18, 1996</b>  |   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Evan Chapell MD</b>  |   | 31. Date filed (Month, Day, Year)<br><b>APR 18 1996</b>   |   |  |  |   |  |  |
| 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |   |   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12436

|  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Elisabeth Wilhelmine Wilder</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 13 1996</b>   |  |   |  | 3. Time of Death<br><b>820 P</b>  |  |  |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>10210 Mackall Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>St. Leonard</b>   |  |   |  | 4c. County of Death<br><b>Calvert</b>   |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215 44 6243</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 22 1936</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b> |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>St. Leonard</b>  |  |   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br><b>10210 Mackall Road</b>  |  |   |  | 10f. Zip Code<br><b>20685</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>clerk</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>retail sales</b>                                       |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Franz Jacob</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wilhelmine Muller</b> |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elfriede R. Smith/daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10210 Mackall Road St. Leonard, Maryland 20685</b>   |  |   |  |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calvary Bible Church Cemetery</b>   |  |   |  | 20c. Location - City or Town, State<br><b>St. Leonard Maryland</b>                          |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Braun</b>  |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home<br/>4405 Brookes Is. Rd. Port Republic Maryland</b>   |  |   |  |   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC CANCER BREAST</b><br>Due to (or as a consequence of):<br><b>b. CANCER BREAST</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>6 months</b><br><b>1 1/2 yrs</b> |  |   |  |  |  |   |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b>  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |  |  |
|  |  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><b>SK</b>   |  |   |  | 29c. License number<br><b>D36965</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/15/96</b>  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SCARIA MATHEW MD 11910 H.C. TRUENMAN RD LUSBY MD 20657</b>  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1996</b>  |  |   |  | 32. Registrar's Signature<br><b>Davidson-Randall</b>   |  |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12437

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Bertha Marie Woolford  |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 14 1996   |  | 3. TIME OF DEATH<br>12:25 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-22-7827   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>70 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 13, 1925  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Dorchester General Hospital  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cambridge  |  | 9c. COUNTY OF DEATH<br>Dorchester   |  |
| RESIDENCE OF DECEDENT  |  |   |   |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Dorchester   |   | 10c. CITY, TOWN OR LOCATION<br>Cambridge  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1248 Hudson Road   |  |   |   | 10f. ZIP CODE<br>21613  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>US   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify White                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Sewing Factory  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Roland Albert Mowbray   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rena Marie Bargman   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Roland C. Woolford   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1248 Hudson Rd. Cambridge, Maryland 21613  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Md. Veterans Cemetery 4/16   |   | 20c. LOCATION — City or Town, State<br>Hurlock, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Thomas Funeral Home, P.A.<br>700 Locust St. Cambridge, Md. 21613  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>MYOCARDIAL INFARCTION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>PNEUMONIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><u>ONE DAY</u><br><u>TWO WEEKS</u><br><u>TWO DAYS</u> |  |   |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |   |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> D.O.   |  |   |   | 29c. LICENSE NUMBER<br>044532   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/14/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JACK L. SNITZER, D.O. 19 Franklin St. Cambridge Md 21613  |  |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 16 1996   |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





96 12438

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET Irene WELSH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 1, 1996</b>  |  | 3. TIME OF DEATH<br><b>1:45A.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-18-1309</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 30, 1914</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Allegany</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>Willow Valley Apts Furnace Street</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21502</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housekeeping</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Emanuel Perry Welsh</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel Lillie Troutman</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ronald Steele</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11818 Valley Rd. N.E. Cumberland, Md. 21502</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SUNSET Memorial Park 4-4-96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ernest A. Riley, Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leisure-SPAIN, INC. 230 Baltimore Ave. Cumberland, Md. 21502</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Acute Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Acute Asthmatic Bronchitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>10 Days</b><br><b>10 Days</b>                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 33280</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 2, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Gupta, Johnson Heights Medical Building 625 Kent Avenue, Suite 101 Cumberland, MD 21502</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 03 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12439

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RITA ANN WILLIAMS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>5</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>5:17 A M</b>                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 22 6780</b>  |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 4, 1926</b>             |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>120 ARMSTRONG STREET</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FROSTBURG</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>                                  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ALLEGANY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FROSTBURG</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                           |  |
| 10e. STREET AND NUMBER<br><b>120 ARMSTRONG STREET</b>  |  |  |  | 10f. ZIP CODE<br><b>21532</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                            |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BERNARD MARTIN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HILDA DELANEY</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAMEY WILLIAMS</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>120 ARMSTRONG ST., FROSTBURG, MD 21532</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK, 4/8/96</b>                            |  | 20c. LOCATION — City or Town, State<br><b>FROSTBURG, MD 21532</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael M. Sowers</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>                                   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE</b><br><b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CHRONIC OBSTRUCTIVE LUNG DIS</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPOTHYROIDISM</b>  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |   |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                               |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Victor E. Mazzocco</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D07135</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 5, 1996</b>             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>VICTOR E. MAZZOCCO, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12440

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD WARE, JR.

2. Date of Death

Month Day Year  
APRIL 03 96

3. Time of Death

19:51

4a. Facility Name (If not institution, give street and number)

BAY VIEW BURN CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

209-62-5932

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 11 1967

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

PA.

10b. County

BEDFORD

10c. City, Town or Location

BEDFORD

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

RFD# 3 BOX# 432 LAKE GORDON ROAD

10f. Zip Code

15522

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COVER LUMBER CO.

16b. Kind of Business/Industry

LOGGER

17. Father's Name (First, Middle, Last)

RONALD L. WARE SR.

18. Mother's Name (First, Middle, Maiden Surname)

SUNDRA LEE AUSHERMAN

19a. Informant's Name/Relationship (Type, Print)

CHRISTINE WARE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RFD#3 BOX#432 BEDFORD, PA. 15522

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET CEMETERY

Date

APRIL 8 1996

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL ISCHEMIA; ARRHYTHMIA

Due to (or as a consequence of):

b. 85% TBSA BURNS

Due to (or as a consequence of):

c. INHALATION LUNG INJURY

Due to (or as a consequence of):

d. ACUTE SYSTEMIC REACTION TO BURN (STRBSS RESPONSE) 24 HRS

Approximate Interval Between Onset and Death

20 min

24 HR

24 HRS

24 HRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MASSIVE FLUID REQUIREMENTS (REPLACEMENT)

HYPERKALEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

☐ Natural 5 ☐ Pending Investigation  
☒ Accident 6 ☐ Could not be determined  
☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
04/02/96

28b. Time of Injury

7:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

GAS TANK EXPLOSION WHILE LIGHTING GAS STOVE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. S. S. FELLOW BURNS/PLASTICS

29c. License number

2050

29d. Date signed (Month, Day, Year)

04/03/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. KUNDEEP SINGH, DEPT. OF SURG., ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD. 21229

31. Date filed (Month, Day, Year)

APR 05 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12441

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA EVELINE WITT</b>  |  |   |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>3</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>0300 AM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>                      |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215 34 4841</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUL 3, 1935</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>FROSTBURG</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. Street and Number<br><b>10027 PARKERSBURG ROAD, NW</b>   |  |   |  | 10f. Zip Code<br><b>21532</b>   |  | 10g. Citizen of What Country?<br><b>U.S.</b>  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College (1-4or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JAMES MATTHEWS</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERONA SNYDER</b>   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>KENNETH R. WITT</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10027 PARKERSBURG ROAD, NW, FROSTBURG, MD 21532</b>                                       |  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SUNSET MEMORIAL PARK, 4/6/96</b>                                     |  | Date<br><b>MD 21532</b>   |  | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD 21502</b>  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Wilton M. Sowers</i>  |  |   |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A., 60 W. MAIN ST, FROSTBURG</b>  |  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SEPSIS &amp; SEPTIC SHOCK</b> 5 DAYS<br>Due to (or as a consequence of):<br>b. <b>ASCITES, PLEURAL EFFUSION</b> 2 YRS<br>Due to (or as a consequence of):<br>c. <b>CIRRHOSIS OF THE LIVER</b> 20 YRS<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b><br><b>HYPERTENSION</b> |  |   |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br><i>Chang OH M.D.</i>   |  | 29c. License number<br><b>D24951</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 3, 1996</b> |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chang OH M.D. 48 Tarn Terrace Frostburg, MD 21532</b>  |  |   |  |   |  |   |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 05 1996</b>   |  | 32. Registrar's Signature<br><i>J. H. [Signature]</i>   |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

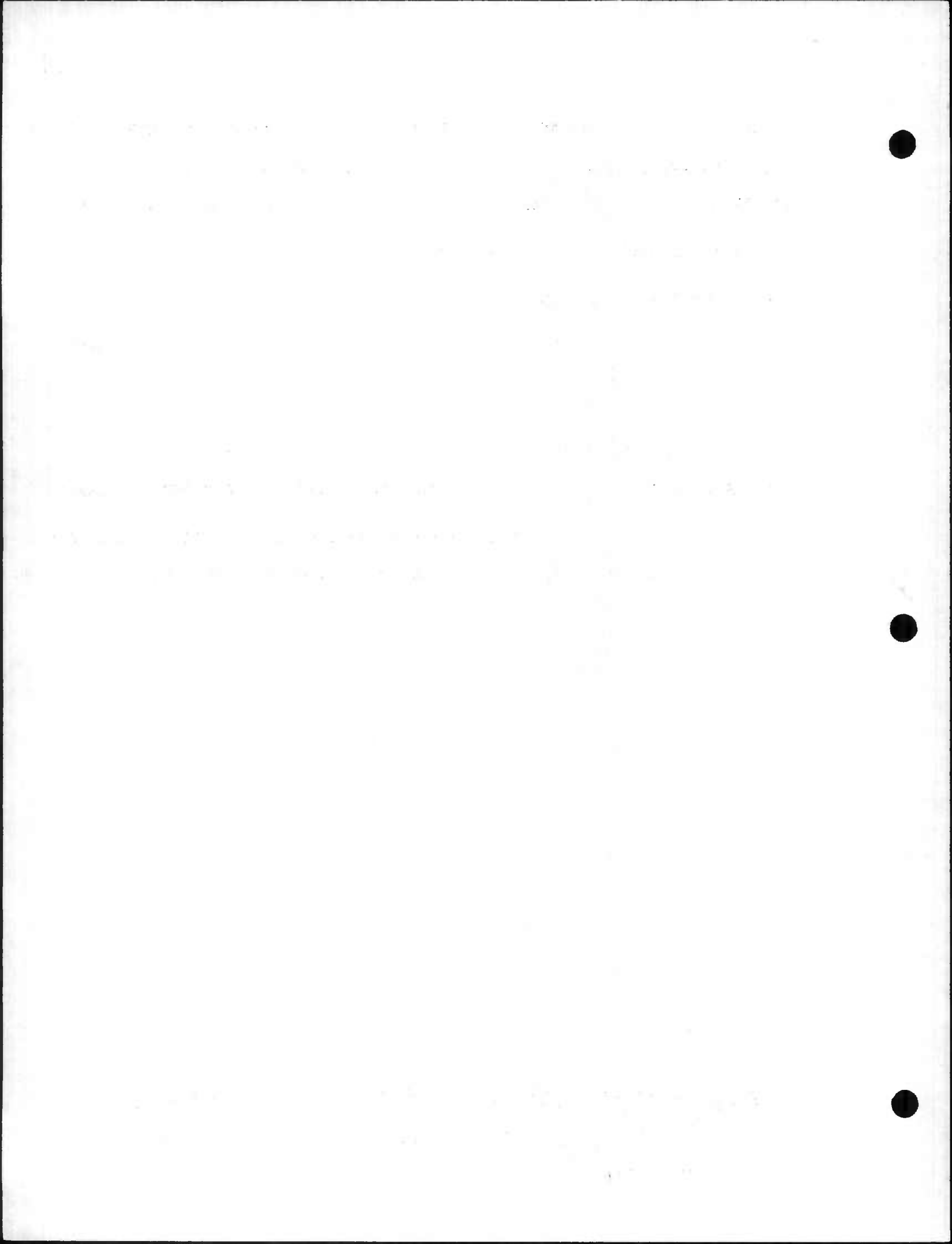
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





AMENDED # 4, MA, ACHD, 4/12/96  
 AMENDED # 20C, Del, ACHD, 4-11-96

96 12442

FOR  
 STATE  
 REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Earl Matthew Whetsel</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 7 1996</b>   |  | 3. TIME OF DEATH<br><b>9:16 P. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>323-03-0565</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 5 1907</b>                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WEST VIRGINIA</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| 9b. RESIDENCE OF DECEDENT (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>568 Patterson Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1944 - 1945</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White U.S.A.</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MEAT CUTTER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL MARKET</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN WHETSEL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JULIA HEISHMAN</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GENEVIEVE V. WHETSEL</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>568 PATTERSON AVE. - CUMBERLAND, MD 21502</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SUNSET MEMORIAL PARK 4/10/96</b>   |  | 20c. LOCATION (City or Town, State)<br><b>CUMBERLAND, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Udendy N. Upchurch</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio pulmonary arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>d.</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Type II Diabetes</b><br><b>Aortic Stenosis</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>V.B. Felipa MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D13601</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/9/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>V.B. Felipa, M.D. - 925 Bishop Walsh - Cumberland, MD 21502</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 11 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12443

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |   |  |   |
|--|---|--|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hilda Mary Watkins  |  |   |  | 2. Date of Death<br>Month: April Day: 3 Year: 1996   |   | 3. Time of Death<br>05:45  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Hagerstown   |   | 4c. County of Death<br>Washington                                |   |
| Funeral<br>Director  | 5. Social Security Number<br>210-24-9464  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Sept. 6, 1917             |   |
|  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  | 10a. State<br>Pa.   |  | 10b. County<br>Huntingdon  |   | 10c. City, Town or Location<br>Robertsdale                       |   |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>HC 1 Box 57   |  | 10f. Zip Code<br>16674   |   | 10g. Citizen of What Country?<br>U.S.A.                          |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 8 College (1-4 or 5+): 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |  | 16b. Kind of Business/Industry<br>home   |   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>Levi Johnson   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances Kirk Stunkard   |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Norman C. Watkins/ spouse   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>HC1 Box 57 Robertsdale, Pa. 16674   |   |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Wells Valley Pres. Cem  |  | 20c. Location - City or Town, State<br>4/6 Wells Tannery, Pa.  |   |  |   |
|  | 21. Signature of Funeral Service Licenses<br><i>Michael C. Burner</i>   |  |   |  | 22. Name and Address of Facility<br>Burner Trade Services<br>1037 Dual Pl. Hagerstown, Md. 21740   |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Pneumonia</i><br>Dua to (or as a consequence of):<br>b.<br>Dua to (or as a consequence of):<br>c.<br>Dua to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |   |
|  | Approximate Interval Between Onset and Death<br>1 Month   |  |   |  |  |   |  |   |
|  | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive pulmonary disease</i><br><i>Diabetes Mellitus</i>   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |   |
|  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of injury (Month, Day Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
|  |   | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |  |   |
|  | 29b. Signature and title of certifier<br><i>Michael C. Burner</i>   |  | 29c. License number<br>02457  |  | 29d. Date signed (Month, Day, Year)<br>4/3/96  |   |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ABOUL WAHED, MD - 12821 Oak Hill Ave. HAGERSTOWN, MD 21742  |  |   |  |  |   |  |   |
|  | 31. Date filed (Month, Day, Year)<br>APR 04 1996  |  | 32. Registrar's Signature<br><i>John G. ...</i>   |  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12444

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |   |  |  |
|---|---|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Louise Whitehead</u>   |  |   | 2. Date of Death<br>Month <u>April</u> Day <u>2</u> Year <u>1996</u> |  |  | 3. Time of Death<br><u>11:05AM</u>   |   |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><u>Shady Grove Adventist Hospital</u>   |  |   | 4b. City, Town, or Location of Death<br><u>Rockville</u>             |  |  | 4c. County of Death<br><u>Montgomery</u>   |   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>234-36-5154</u>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>Oct. 17, 1921</u>                          |   | 9. Birthplace (State or Foreign Country)<br><u>Virginia</u>  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>Montgomery</u>  |  | 10c. City, Town or Location<br><u>Damascus</u>   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><u>9821 Bethesda Church Road</u>  |  |   |  | 10f. Zip Code<br><u>20872</u>  |  | 10g. Citizen of What Country?<br><u>United States</u>                                |   |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>12</u>  |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>  |  |  | 16b. Kind of Business/Industry<br><u>Own Home</u>                       |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><u>Andrew Jackson Sheets</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Georgia Osborne</u>  |  |  |   |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><u>James Robert Whitehead/ Son</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>9821 Bethesda Church Road, Damascus, Md. 20872</u>   |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Maplewood Cemetery</u>   |  | Date<br><u>April 8, 1996</u>   |  | 20c. Location - City or Town, State<br><u>Tazwell, Virginia</u>                      |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  | 22. Name and Address of Facility<br><u>Olin L. Molesworth P.A., Funeral Home</u><br><u>26401 Ridge Road. Damascus, Maryland 20872</u>   |  |  |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>UROSEPSIS</u><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><u>12 Hours</u>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CONGESTIVE CARDIOMYOPATHY</u><br><u>CEREBRAL INFARCTION</u><br><u>DIABETES MELLITUS</u>  |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the causa of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><u>M</u>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|   | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><u>[Signature]</u> <u>James Michael Anchor MD</u>  |  | 29c. License number<br><u>D29730</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>APRIL 2, 1996</u>                          |   |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>JAMES MICHAEL ANCHORS MD 16220 FREDERICK RD. GAITHERSBURG, MD</u>  |  |   |  |  |  |  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><u>APR 08 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12445

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>George Raymond Wilson</i>                     |   |  |  | 2. Date of Death<br>Month <i>April</i> Day <i>5</i> Year <i>1996</i> |  | 3. Time of Death<br><i>6 AM</i>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>9018 Lynnalán Drive</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Fort Washington</i>       |  | 4c. County of Death<br><i>Prince George's</i>              |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>577-4283-46</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>68</i> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>1-26-1928</i> | 9. Birthplace (State or Foreign Country)<br><i>Miami, Florida</i>  |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Prince George's</i>   |  | 10c. City, Town or Location<br><i>Fort Washington</i>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><i>9018 Lynnalán Drive</i>  |  |   |  | 10f. Zip Code<br><i>20744-3620</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>11-7-50 / 6/20/52</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Retired Tile Mechanic</i>  |  | 16b. Kind of Business/Industry<br><i>Private</i>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Jesse Wilson</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Linda Bethal</i>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Joycelyn M. Canary - Daughter</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9018 Lynnalán Drive, Ft. Washington, MD 20744-3620</i>                                   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Veterans Cemetery 4/10/96 Cheltenham, MD</i>  |  | Date   |  | 20c. Location - City or Town, State  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>John T. Stewart III</i>   |  |   |  | 22. Name and Address of Facility<br><i>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N.E., Washington, D. C.</i>   |  |  |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Arteriosclerotic cardiovascular disease</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how Injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Augusto J. Dominguez MD</i>   |  |  |  |  |  |  |
|   |  | 29c. License number<br><i>A21230</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>April 5, 1996</i>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Andrés A. P. Rodríguez MD, 5009 Rayburn Ct. Cp Spr Md 20748</i>  |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1996</b>   |  | 32. Registrar's Signature<br><i>John A. ...</i>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(5) 114

State  
Registrar

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818



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State of Maryland / Department of Health and Mental Hygiene

96 12446

Certificate of Death

Reg. No.

Amended #5 4/8/96 ELM P.G.C.

|   |   |   |   |  |  |  |  |   |  |
|---|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LARRY WILLIAMS</b>                                   |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>4</b> Year <b>1996</b> |  | 3. Time of Death<br><b>10:00 P</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>               |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>239-04-3886</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                            | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1958</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince Georges</b>  |   | 10c. City, Town or Location<br><b>Temple Hills</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>3008 Brinkley Road #T1</b>   |   |   |   | 10f. Zip Code<br><b>20746</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  |  | 16b. Kind of Business/Industry<br><b>Government</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Turner Williams</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bennie Mae Baker</b>   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Troy Thompson/Nephew</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1216 Anne Street Rocky Mount, N.C. 27801</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b> |  | Date<br><b>4/9/96</b>  |  | 20c. Location - City or Town, State<br><b>Beltsville, MD</b>                                   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Kimberly C Busck-Tonic</b>  |   |   |   | 22. Name and Address of Facility<br><b>J.B.JENKINS FUNERAL HOME<br/>7474 LANDOVER ROAD LANDOVER, MD 20785</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. AIDS</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 years.</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- Kaposi's Sarcoma, Renal Failure</b>  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 26a. Date of Injury (Month, Day Year)   |   | 26b. Time of Injury<br><b>M</b>  |  | 26c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26d. Describe how injury occurred   |  |
|   |   | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 26f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                      |   | 29b. Signature and title of certifier<br><b>Sam J. [Signature]</b>  |   | 29c. License number<br><b>D34 274</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-5-96</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ESSAM TELLANI 7700 OLD BARNETT AVE CLINTON MD 20735</b>  |   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1996</b>   |   |   |   | 32. Registrar's Signature<br><b>John Davidson-Rodall</b>   |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12447

## Certificate of Death

Reg. No.

|   |   |  |   |                                      |   |   |  |  |
|---|---|--|---|--------------------------------------|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ERIC NORBERT FRANKLYN YOUNG</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>APRIL 2 1996</b>   |   | 3. Time of Death<br><b>5:00 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-68-0302</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 17, 1942</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Jamaica, W.I.</b>  |  | 10a. Usual Residence of Decedent<br>10e. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b>   |                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10f. Zip Code<br><b>20904</b>  |  |
| To Be Completed by Funeral Director   | 10g. Citizen of What Country?<br><b>Jamaica, W.I.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Consultant</b>   |   | 16b. Kind of Business/Industry<br><b>Self Employed</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Horace George Young</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ena Rose Downey</b>   |                                      | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lesline M. Young</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20904 3061 Shepperton Ter. (Silver Spring, Md.)</b>                                      |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven</b>   |                                      | 20c. Date<br><b>4/11/96</b>   |   | 20d. Location - City or Town, State<br><b>Silver Spring, Md.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Jordan Funeral Service, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019)</b>  |                                      | 23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ACUTE MASSIVE INTRACEREBRAL HEMORRHAGE</b>                       |   | Approximate Interval Between Onset and Death<br><b>4 DAYS</b>  |  |
|   | 23b. Immediate Cause (Final disease or condition resulting in death)<br><b>HYPERTENSION</b>   |  | Due to (or as a consequence of):  |                                      | Due to (or as a consequence of):  |   | Due to (or as a consequence of):   |  |
|   | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Due to (or as a consequence of):  |                                      | Due to (or as a consequence of):  |   | Due to (or as a consequence of):   |  |
|   | 23d. Pertinent conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |                                      | 23f. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  |
|   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                      | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Steven T. Karna - MD</b> |   | 29c. License number<br><b>D36252</b> |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 9, 1996</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEVEN T. KARNA, MD, 11501 GEORGIA AVE #515 WHEATON MD 20902</b>   |   | 31. Date filed (Month, Day, Year)<br><b>APR 10 1996</b>              |   | 32. Registrar's Signature<br>        |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar



96 12448

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET HELENA ZILER</b>  |  |  |  | 2. DATE OF DEATH<br><b>MARCH 29, 1996</b>   |  | 3. TIME OF DEATH<br><b>8:18 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 52 9356</b>   |  | 5. SEX<br><b>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec 12, 1900</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Allegany</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><b><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</b>  |  | 10e. STREET AND NUMBER<br><b>734 Baker Street</b>   |  |
| 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:                  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Office Employee</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B &amp; O Railroad</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John J. Carney</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Helena (Keenan)</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Martine Bible</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Route 2 Box 181; Cumberland, MD 21502</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SS Peter Paul Cemetery 04/01</b>               |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Scarpelli</b>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home Cumberland, MD 21502</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Myocardial infarction</b><br><b>Atherosclerotic cardiovascular disease</b> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |   |  |
| 26. MANNER OF DEATH<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b>  |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br><b>M</b>   |  | 26c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>   |  |
| 26d. DESCRIBE HOW INJURY OCCURRED   |  | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 27. CERTIFIER (Check only one)<br><b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  | 28. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Anthony Bollino</b>  |  |   |  |
| 29. LICENSE NUMBER<br><b>017565</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Apr 3, 1996</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR ANTHONY BOLLINO 955 FREDERICK ST CUMBERLAND, MD 21502</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 04 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane Anderson</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12449

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CAROLINE BERG ZSAKANY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 15, 1996</b>   |  | 3. TIME OF DEATH<br><b>5:10 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-01-2742</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 10, 1918</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHARLES COUNTY NURSING &amp; REHAB. CTR.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LA PLATA</b>  |  | 9c. COUNTY OF DEATH<br><b>CHARLES</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TEMPLE HILLS</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4008 21ST. PLACE</b>  |  |  |  | 10f. ZIP CODE<br><b>20748</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ACCOUNTANT</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEPARTMENT OF LABOR<br/>FED. GOVERNMENT</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FREDERICK ANDREW BERG</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HATTIE J. SLOBOHUM</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN C. ZSAKANY</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4008 21ST. PLACE TEMPLE HILLS, MARYLAND 20748</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON NATIONAL CEM. 4/23</b>   |  | 20c. LOCATION — City or Town, State<br><b>ARLINGTON, VIRGINIA</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Benjamin M. Matthews</i><br><b>BENJAMIN M. MATTHEWS M-00658</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND 20604</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Alzheimer's disease</b>   |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| b. <b>Malnutrition &amp; Dehydration</b><br>c. <b>R/O Sepsis, Hypotension</b><br>d. <b>R/O Pulmonary Embolism</b>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Altered mental status, bedridden for long period of time, cerebral atrophy, feeding problems</b>  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ali Reza Zadeh MD</i><br><b>ALI REZAZADEH, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>MD 246938</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 15, 1996</b>                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALI REZAZADEH, MD #2 ST. PATRICKS DRIVE, SUITE 502 WALDORF, MARYLAND 20601</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 16 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12450

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor A. Zeisler

2. Date of Death

Month Day Year  
April 4, 1996

3. Time of Death

9:21 AM

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

272 32 7611

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 31, 1908

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Ohio

10b. County

Hamilton

10c. City, Town or Location

Cincinnati

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2964 W. Tower Drive

10f. Zip Code

45238

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Frank Kerley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ladrikan

19a. Informant's Name/Relationship (Type, Print)

Alice Bartish

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1063 Tahoe Terrace Cincinnati Ohio 45238

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington Memorial 4/10/96

Date

20c. Location - City or Town, State

Mt. Healthy Ohio

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

b. L Hemiparesis stroke

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

Colonic-vesicle fistulae

osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Rhodes M.D.

29c. License number

022028

29d. Date signed (Month, Day, Year)

4-5-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Rhodes M.D. 1667 Crofton Centre Suite 1 Crofton Maryland 21114

31. Date filed (Month, Day, Year)

APR 12 1996

32. Registrar's Signature

John P. Rhodes

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

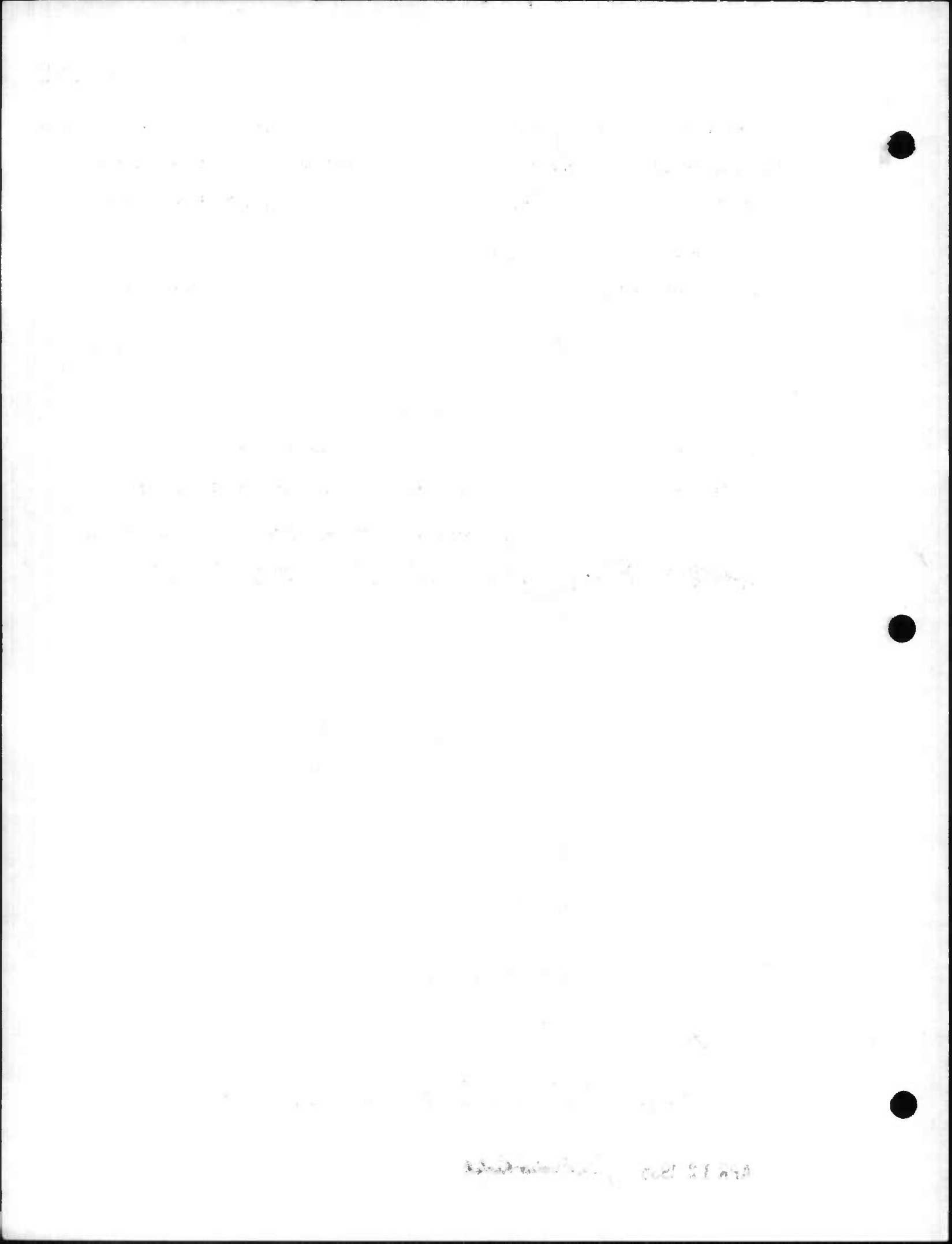
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

96 12451

## Certificate of Death

Reg. No.

|   |  |                          |  |  |  |  |  |  |  |
|---|--|--------------------------|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Anna Roberta Auld                      |                          |  |  |  | 2. Date of Death<br>April 25, 1996   |  | 3. Time of Death<br>4:15 p.m.                  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>1321 Willow Road |                          |  |  |  | 4b. City, Town, or Location of Death<br>Dundalk  |  | 4c. County of Death<br>Baltimore               |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-34-3594   |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br>60 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 4, 1935  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |
|   | Usual Residence of Decedent  |                          |  |  |  |  |  |  |  |
| 10e. State<br>Maryland  |  | 10b. County<br>Baltimore |  | 10c. City, Town or Location<br>Dundalk   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1321 Willow Road  |  |                          |  | 10f. Zip Code<br>21222   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 years<br>College (1-4 or 5+) _____  |  |                          |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Walter Michael   |  |                          |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Roberta Shlee   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ruth R. Poswiatowsky (Daughter)   |  |                          |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2 Lombardi Drive Baltimore, Maryland 21222  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery  |  | Date<br>4/29/96  | 20c. Location - City or Town, State<br>Glen Burnie, Maryland   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Johnny L. [Signature]  |  |                          |  |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. Lung Cancer, METASTATIC<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br>6 mos |  |                          |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                          |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |  |                          |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   |  |                          |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |                          | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |  |
|   |  |                          | 28d. Describe how injury occurred  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                          | 29b. Signature and title of certifier<br>Michael [Signature]   |  |  | 29c. License number<br>D33551  |  | 29d. Date signed (Month, Day, Year)<br>4/26/96 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MICHAEL AUERBACH 9000 FRANKLIN Sq Dr. 21237   |  |                          |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996  |  |                          | 32. Registrar's Signature<br>[Signature]   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12452

Certificate of Death

Reg. No.

|  |  |                           |   |  |  |  |  |  |   |  |
|--|--|---------------------------|---|--|--|--|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS RAY ANDERSON</b>   |                           |   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1996</b>                          |  | 3. Time of Death<br><b>5:19 P.M</b>                          |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA UNIT</b>   |                           |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                       |  | 4c. County of Death<br><b>n/a</b>                            |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>219-52-8227</b>  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>APR. 24, 1950</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>DANVILLE, VA</b> |  |
|  | Usual Residence of Decedent  |                           |   |  |  |  |  |  |   |  |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br><b>MD</b>  | 10b. County<br><b>m/a</b> | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |
|  | 10e. Street and Number<br><b>707 W. LANVALE STREET</b>   |                           |   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7 th</b> College (1-4or 5+) <b>-</b>   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CEMENT FINISHER</b>   |  |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>PERCELL ANDERSON</b>   |                           |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>OLIVIA SLADE</b>                       |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PERCELL ANDERSON</b>  |  |                           |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>707 W. LANVALE ST., BALTIMORE, MD 21217</b>  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>VOSHALL MEMORIAL PARK</b>  |  | Date<br><b>4-30</b>  |  | 20c. Location - City or Town, State<br><b>DUNDALK, MD</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                           |   |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Gunshot Wound of Abdomen with Complications</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                           |   |  |  |  |  |  |   | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                           |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |                           |   |  |  |  | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|  |  |                           |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                           | 28a. Date of Injury (Month, Day, Year)<br><b>4-9-1996</b>   |  | 28b. Time of Injury<br><b>4:40 P.</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>SUBJECT SHOT</b>        |  |
|  |  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>ON STREET</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>700 BLK.W.LANVALE STREET</b>  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                           | 29b. Signature and title of certifier<br><br><b>Dennis J. Chute MD</b>   |  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1996</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |                           |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |  |                           |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12453

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|--|---|---|---|---|--|---|---|--|---|-------------------------------------|---|----------------------|---------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA RUTH BROWN</b>  |   |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>12:50 AM</b>                                     |  |   |                                     |   |                      |               |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Allegis Nursing Home</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>                              |  |   |                                     |   |                      |               |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-64-6951</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>April 29, 1898</b>            |  |   |                                     |   |                      |               |    |  |    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Unknown</b>  |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Glen Burnie</b>                       |  |   |                                     |   |                      |               |    |  |    |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>7355 Furnace Branch Road East</b>  |   | 10f. Zip Code<br><b>21060</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |                                     |   |                      |               |    |  |    |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                     |   |                      |               |    |  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unknown</b>                       |   | 16b. Kind of Business/Industry<br><b>Unknown</b>   |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Unknown</b>  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ginger Blessing/Social Worker</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7355 Furnace Branch Rd. East Glen Burnie, MD 21060</b>                                   |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |   | Data<br><b>04/25/96</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |   |                                     |   |                      |               |    |  |    |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Dawn F. McDonald</b>  |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>                          |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
|  | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>LEFT LOWER LOBE PNEUMONIA</b></td> <td>Approximate Interval Between Onset and Death<br/><b>5 days</b></td> </tr> <tr> <td>b. <b>ASPIRATION</b></td> <td><b>5 days</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |   |  |   |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>LEFT LOWER LOBE PNEUMONIA</b> | Approximate Interval Between Onset and Death<br><b>5 days</b> | b. <b>ASPIRATION</b> | <b>5 days</b> | c. |  | d. |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <b>LEFT LOWER LOBE PNEUMONIA</b>   | Approximate Interval Between Onset and Death<br><b>5 days</b>   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| b. <b>ASPIRATION</b>   |   | <b>5 days</b>   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| c.   |   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| d.   |   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEIZURE DISORDER</b><br><b>SCHIZOPHRENIA</b><br><b>CORONARY ARTERY DISEASE</b>  |   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                                     |   |                      |               |    |  |    |  |
| 28d. Describe how injury occurred  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |   | 29c. License number<br><b>AS 2441614-57</b> |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23 1996</b>                                 |   |  |   |                                     |   |                      |               |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THOMAS GEORGE, HARBOR HOSPITAL CENTER 301 S. HANOVER ST. BALTIMORE 21225 MD.</b>  |   |   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |   |   |  |   |                                     |   |                      |               |    |  |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12454

ITEM#1&12 film g734 4/29/96ag perFH Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |   |                                |   |  |
|--|--|---|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><u>John Moody Brewer</u>   |  |   |  | 2. Date of Death<br>Month <u>04</u> Day <u>24</u> Year <u>96</u>  |                                | 3. Time of Death<br><u>3:00pm</u>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><u>University Hospital</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>  |                                | 4c. County of Death<br><u>N/A</u>   |  |
| 5. Social Security Number<br><u>219-26-9843</u>  |  | 6. Sex<br><u>1</u> M <u>2</u> F   | 7. Age (In yrs. last birthday)<br><u>55</u> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><u>MAY 27, 1940</u>                |  |
| 9. Birthplace (State or Foreign Country)<br><u>S. Carolina</u>   |  |   |  |   |                                |   |  |
| Usual Residence of Decedent  |  |   |  |   |                                |   |  |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>N/A</u>   |  | 10c. City, Town or Location<br><u>Baltimore</u>   |                                | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                       |  |
| 10e. Street and Number<br><u>1506 Windemere Avenue</u>   |  |   |  | 10f. Zip Code<br><u>21218</u>   |                                | 10g. Citizen of What Country?<br><u>United States</u>                     |  |
| 11. Marital Status<br><u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates: <u>1963-65</u> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>4</u> yrs. College (1-4or 5+)            |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Sanitarian</u>                    |                                | 16b. Kind of Business/Industry<br><u>Dept. of Health &amp; Sanitation</u> |  |
| 17. Father's Name (First, Middle, Last)<br><u>James Brewer</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Almeta Hough</u>  |                                |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Jane Brewer</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1506 Windemere Ave., Baltimore, MD 21218</u>  |                                |   |  |
| 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Garrison Forest VA Cem.</u>              |  | Date<br><u>4/29/96</u>  |                                | 20c. Location - City or Town, State<br><u>Owings Mills, MD</u>            |  |
| 21. Signature of Funeral Service Licensee<br><u>L. Valencia Holland</u>  |  |   |  | 22. Name and Address of Facility<br><u>March Funeral Home</u><br><u>1101 E. North Avenue, Baltimore, MD 21202</u>                                 |                                |   |  |

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | <u>a. Left Temporal Intracerebral Hemorrhage</u><br>Due to (or as a consequence of):<br><br><u>b. Hypertension</u><br>Due to (or as a consequence of):<br><br><u>c.</u><br>Due to (or as a consequence of):<br><br><u>d.</u><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><u>36 hours</u> |  |
|--|--|--|--|---|--|

Medical Certification: To Be Completed by Physician/Medical Examiner

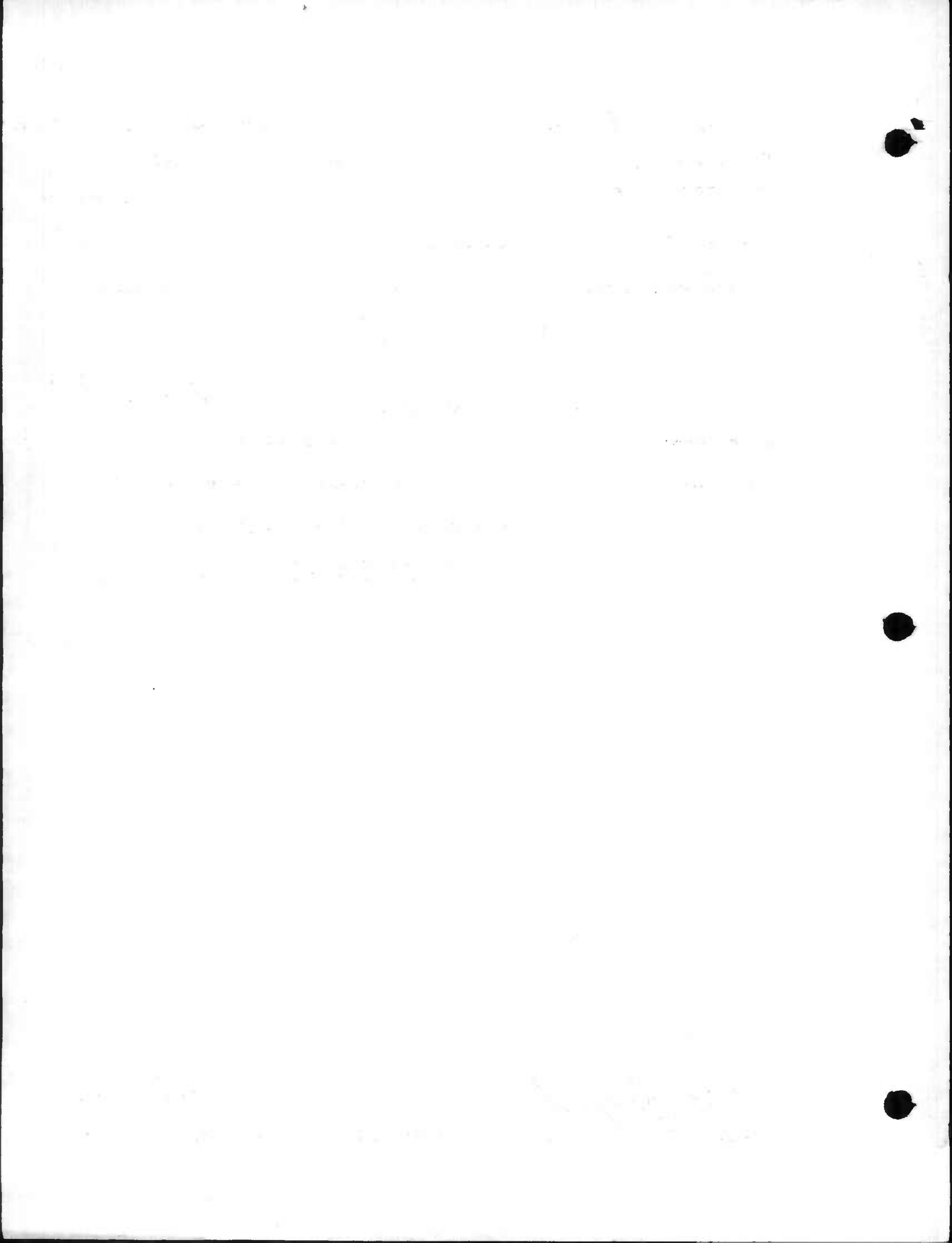
|   |  |  |  |   |  |
|---|--|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes</u><br><u>End stage Renal Disease</u>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown |  |
| 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No  |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |  |   |  |
| 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide<br><u>4</u> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><u>M</u>   |  |
| 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No  |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br><u>Bobo Bright</u>   |  | 29c. License number<br><u>P05459</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>4/24/96</u>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>22 S. Greene Street, Baltimore MD 21201</u>  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1996</u>   |  | 32. Registrar's Signature<br><u>Julia D. Anderson-Randall</u>  |  |   |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

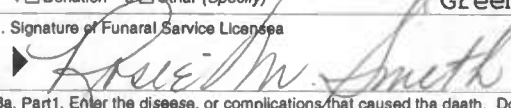
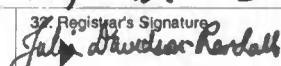
State of Maryland / Department of Health and Mental Hygiene

96 12455

ITEM#1 film g734 4/29/96ag perFH

Certificate of Death

Reg. No.

|  |   |   |   |  |   |   |  |   |  |
|--|---|---|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE GENE L. BRIGHT</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 22, 1996</b>   |   | 3. Time of Death<br><b>8:20 A.M.</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1230 N. Aisquith Street</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>N/A</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-36-5994</b>   |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>54 Yrs.</b> | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 30, 1941</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |   |  |   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>1230 N. Aisquith Street</b>  |   |   |  | 10f. Zip Code<br><b>21202</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>-</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |   | 16b. Kind of Business/Industry<br><b>Hospital</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Goliath Bright</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Scott</b>   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rebecca Bright</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1230 N. Aisquith Street, Baltimore, MD 21202</b>  |   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>  |  | Data<br><b>4-27-96</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                    |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>March Funeral Home<br/>1101 E. North Avenue, Baltimore, MD 21202</b>   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHRONIC OBSTRUCTIVE PULMONARY DIS. 10 YR.</b><br>Due to (or as a consequence of):<br><b>b. COR PULMONALE 4 YR.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |   | 28b. Time of Injury<br><b>N/A</b> M              |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>N/A</b>             |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Robert A. Wise M.D.</b>   |   |  |   |   |  | 29c. License number<br><b>120775 (MD)</b>                   |  |
|  |   | 29d. Date signed (Month, Day, Year)<br><b>4/26/96</b>   |   |  |   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT A. WISE, M.D. 5501 HOPKINS BAYVIEW CIRCLE, BALTIMORE</b>   |   |   |   |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |   | 32. Registrar's Signature<br>  |   |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death certificate is issued by the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12456

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE ~~LOUISE~~ BAKER

2. Date of Death

Month Day Year  
APRIL 21 1996

3. Time of Death

1035 P.M.

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

310 32 5013

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 10, 1933

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3802 Pascal Avenue Apt. B

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William E. Loomis

18. Mother's Name (First, Middle, Maiden Surname)

Mabel M. Slater

19a. Informant's Name/Relationship (Type, Print)

Luann F. Montgomery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3802 Pascal Avenue Apt. B Baltimore, Md. 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

4/27/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE RENAL FAILURE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

ONE DAY

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. SEPTIC SHOCK

Due to (or as a consequence of):

ONE DAY

c. PNEUMONIA

Due to (or as a consequence of):

SEVEN DAYS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF LUNG WITH BRAIN  
METASTASES.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

AS2441614-14

29d. Date signed (Month, Day, Year)

APRIL 21 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR KUMAR AGGARWAL,

DEPT. OF MEDICINE HARBOR  
HOSPITAL CENTER, BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12457

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br>ALBIN M BLAZUCKI   |   |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 26 1996  |   | 3. Time of Death<br>01:20 A.M.                                   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>GREATER BALTIMORE MEDICAL CENTER   |   |  |   | 4b. City, Town, or Location of Death<br>TOWSON   |   | 4c. County of Death<br>BALTIMORE                                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-09-3173   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>77 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>03/25/1919                | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |
|  | Usual Residence of Decedent  |   |  |   |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>N/A  | 10c. City, Town or Location<br>Baltimore   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No            |  |   |  |
|  | 10e. Street and Number<br>512 S. Kenwood Ave.  |   |  |   | 10f. Zip Code<br>21224   |   | 10g. Citizen of What Country?<br>U.S.A.                          |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 44-46 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 2   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Marine Architect                    |   | 16b. Kind of Business/Industry<br>Shipbuilding   |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Felix Blazucki  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine Popruch   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Albin J. Blazucki Son  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>707 Corbett Rd Monkton, Md 21111  |   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Rosary Cemetery   |   | Data<br>4/29/96  |   | 20c. Location - City or Town, State<br>Baltimore, Md             |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |  |   | 22. Name and Address of Facility<br>David J. Weber Funeral Home<br>401 S. Chester St. Baltimore, Md 21231  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. METASTATIC ADENO CARCINOMA OF PROSTATE<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D19675             |  | 29d. Date signed (Month, Day, Year)<br>04/26/96   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>HARRY S STEVENS 6569 N. CHARLES ST. #700 BALTIMORE, MD 21204   |  |   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  | 32. Registrar's Signature<br>   |  |   |  |   |  |   |  |

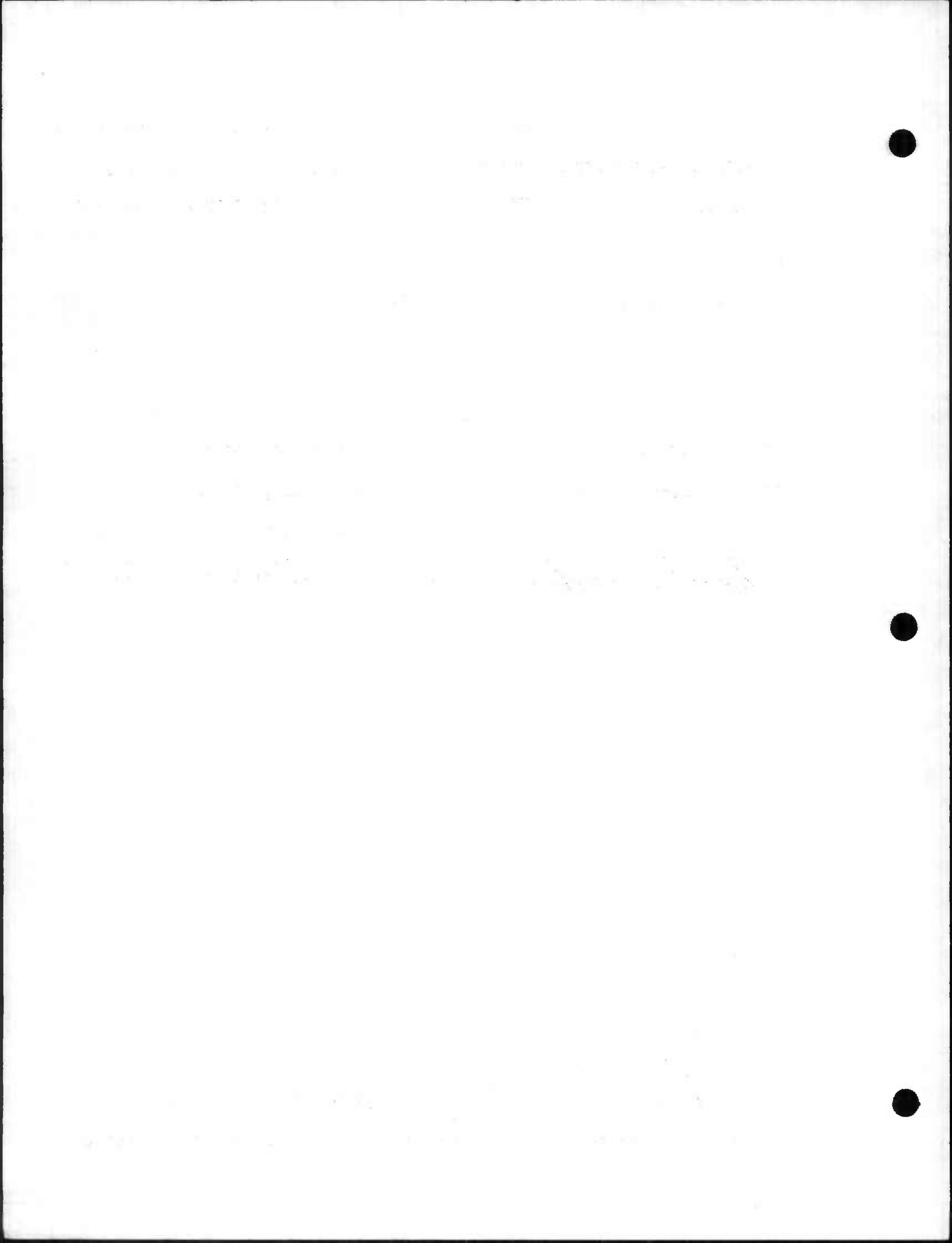
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To be Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

ITEMS: 23PART I, II, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene  
FILM G-735 5/17/96 t.t

96 12458

### Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) CANDISE SUE

2. Date of Death Month Day Year APRIL 26 1996

3. Time of Death 4:30 P.M.

4a. Facility Name (If not Institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death COLUMBIA

4c. County of Death HOWARD COUNTY

5. Social Security Number 215-66-7730

6. Sex 1 Male 2 Female 2

7. Age (In yrs. last birthday) 40 Yrs.

8. Date of Birth (Month, Day, Year) July 22, 1955

9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State MD

10b. County Howard County

10c. City, Town or Location Ellicott City

10d. Inside City Limits 1 Yes 2 No 2

10e. Street and Number 10470 Frederick Road

10f. Zip Code 21042

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 2

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 2

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner Cleaning Service

16b. Kind of Business/Industry Janitorial

17. Father's Name (First, Middle, Last) William Allen Fox

18. Mother's Name (First, Middle, Maiden Surname) Sandra Rider

19a. Informant's Name/Relationship (Type, Print) Mrs. Sandra R. Tucker (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) c/o: 13370 Rt. 144 West Friendship, MD 21794

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1

20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. View Cemetery

20c. Location - City or Town, State 4/30/96 Marriottsville, MD

21. Signature of Funeral Service Licensee Brian L. Haight

22. Name and Address of Facility Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 (410) 795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disease or condition resulting in death)

a. SMALL BOWEL OBSTRUCTION WITH COMPLICATIONS

b. PERITONEAL ADHESIONS

c.

d.

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

STATUS POST SALPINGECTOMY FOR RUPTURED ECTOPIC PREGNANCY

23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier J. L. L. L.

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) APRIL 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. L. L. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) APR 29 1996

32. Registrar's Signature J. L. L. L.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12459

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph David Bowers

2. Date of Death  
Month Day Year

April 24 1996

3. Time of Death

12:18 AM

4a. Facility Name (If not institution, give street and number)

518 Old North Point Road

4b. City, Town, or Location of Death

Eastpoint

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-01-4907

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 3, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Eastpoint

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

518 Old North Point Road

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Samuel Oliver Bowers

18. Mother's Name (First, Middle, Maiden Surname)

Ella Virginia Dickson

19a. Informant's Name/Relationship (Type, Print)

Doris E. Bowers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

518 Old North Point Rd. Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

4/27/96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, MD 2122223a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heat stroke. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Congestive heart failure  
Due to (or as a consequence of):b. Aortic stenosis  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31008

29d. Date signed (Month, Day, Year)

4-24-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David B. Peicher, M.D. 9105 Franklin Sq. Dr. Suite 206 Balt. MD 21224

31. Date filed (Month, Day, Year)

APR 26 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96-2213-510  
96-088

ITEMS: 27,28a-f, PER ME0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12460

FILM G-737 7/30/96 t.t

Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |   |  |  |  |
|---|--|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE MATHIOS CROOK</b>  |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>3:20P.M.</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>110 W.FORT AVE</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-40-0723</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 17, 1931</b>   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>110 W. Fort Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>                       |  |  |  | 16b. Kind of Business/Industry<br><b>Shipyard</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Basil Mathios Crook</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Prudence Richmond</b>   |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Iva Elizabeth McElroy/sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1108 Gregory Avenue Baltimore, MD 21207</b>  |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>04/26/96</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Dawn F. McDonald</b>   |   |   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Smoke Inhalation</b><br>Due to (or as a consequence of):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 4-23-96</b>  |   | 28b. Time of Injury<br><b>3:20 P M</b>           |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                |   | 28d. Describe how injury occurred<br><b>SUBJECT INVOLVED IN HOUSE FIRE</b>   |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>BALTIMORE, MARYLAND</b> |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>  |   |  |  |  |   |  | 29c. License number<br><b>O.C.M.E.</b>       |  |
|   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1996</b>  |   |  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>   |  | 32. Registrar's Signature<br><b>Juba Davidson-Randall</b>   |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

6 + 1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12461

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |   |   |  |  |  |  |
|--|---|---|---|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GRACE COHEN</b>  |   |   |   |  |   | 2. Date of Death<br>Month <b>4</b> - Day <b>27</b> - Year <b>96</b> |  | 3. Time of Death<br><b>12:10 PM</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOUR HOSPITAL</b>  |   |   |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>            |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-10-7567</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 13, 1914</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                              |  |  |
|  | Usual Residence of Decedent   |   |   |   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>2236 W. LEXINGTON ST.</b>  |   |   |   | 10f. Zip Code<br><b>21223</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                      |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>              |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+) <b>N/A</b>  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b>  |  |   | 16b. Kind of Business/Industry<br><b>PRIVATE HOMES</b>              |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN GARVIN</b>   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MATTIE REED</b> |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>HOLBROOK COHEN-SON</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2236 W. LEXINGTON ST. BALTO, MD. 21223</b>   |   |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GOOD HOPE BAPTIST CHURCH CEM. PINELAND, CAROLINA</b>   |  |   | 20c. Location - City or Town, State<br><b>SOUTH</b>                 |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Calvin B. Scruggs Sr.</i>   |   |   | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>  |  |   |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Septic Shock</b><br>Due to (or as a consequence of):<br>b. <b>Possible Acute Abdomen</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____                         |   |   |   |  |   |   |  |  | i day<br>2 day   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic heart Disease</b>   |   |   |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |   |   |   |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |   |   |   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   |   | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   | 29b. Signature and title of certifier<br><i>B. F. ALVING, MD</i>  |   |  | 29c. License number<br><b>D26256</b>                                    |   | 29d. Date signed (Month, Day, Year)<br><b>4/27/96</b>                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BICH DUONG, MD 1940 W. Baltimore St., Baltimore MD 21223</b>  |   |   |   |   |  |   |   |  |  |  |  |
| State Registrar  |   | 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b> |   |   | 32. Registrar's Signature<br><i>Julia...</i>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12462

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARGARET

M.

CROVO

2. Date of Death

Month  
APRILDay  
26Year  
1996

3. Time of Death

3:03 pm.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

A.A. CO

5. Social Security Number

213-12-6068

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
JAN 11, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK MARYLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8125 PARK HAVEN ROAD

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH

College (1-4 or 5+)

N/A

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WM. GETNER

18. Mother's Name (First, Middle, Maiden Surname)

EMMA KEMP

19a. Informant's Name/Relationship (Type, Print)

WILLIAM J. CROVO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8125 PARK HAVEN ROAD DUNDALK MARYLAND 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

NEW CATHEDRAL CEM.

Date

4/30

20c. Location - City or Town, State

BALTIMORE MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME

7527 HARFORD ROAD BALTIMORE MD. 21234

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 15634

29d. Date signed (Month, Day, Year)

4-28-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. KULATHAN GAMM M.D. 3411 BANK STREET BALTO MD 21224

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 12463

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |   |  |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Bessie Cornish   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 24 1996   |                                | 3. TIME OF DEATH<br>10:20 AM  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-74-5133   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>90 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APR. 16, 1906   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>S. CAROLINA  |  |  |   |   |                                |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |                                | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY<br>BALTIMORE   |   | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |                                | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>4512 ALAMEDA   |  |  |   | 10f. ZIP CODE<br>21239  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>6 TH  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DOMESTIC  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>PRIVATE FAMILIES  |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN FIELDING   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>IDAA MAE   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>JULIA WILLIAMS   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4512 ALAMEDA BALTIMORE, MD. 21239  |                                |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>VOSHALL MEM. GARDEN MAY 1 96 BALTIMORE MD.  |   | DATE  |                                | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Mary L. Rollins   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>GARY L. ROLLINS FUNERAL HOME 21701<br>100 WEST ALL SAINTS ST. FREDERICK MD  |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.   |  |  |   |   |                                |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Ischemic bowel<br>DUE TO (OR AS A CONSEQUENCE OF):  |   | 2 days  |                                | Approximate Interval Between Onset and Death  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. Peripheral Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |   | 10 years  |                                |   |  |
|  |  | c. Diabetes Mellitus<br>DUE TO (OR AS A CONSEQUENCE OF):   |   | 15 yrs  |                                |   |  |
|  |  | d.   |   |   |                                |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |                                |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |                                |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>B. H. H. M.D.   |  |  |   | 29c. LICENSE NUMBER<br>AT 2438946 A13   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>4/24/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>BESHARA HELOU - 201 E. UNIV. PARKWAY BALTO, MD 21278  |  |  |   |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 29 1996   |  | 32. REGISTRAR'S SIGNATURE<br>John H. H. H.   |   |   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 12464

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mamdouh Osman Darwish  |  |  |  | 2. DATE OF DEATH<br>MONTH April DAY 23 YEAR 1996   |  | 3. TIME OF DEATH<br>7:40 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-64-2334   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>60 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 29 1935   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Egypt  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1910 Lyden Rd.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Timonium  |  |
| 9c. COUNTY OF DEATH<br>Baltimore   |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>Timonium  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>1910 Lyden Rd.   |  |
| 10f. ZIP CODE<br>21093   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) +14  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Medical Doctor  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Chief Of Nephrology  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Martin Sheridan, MD.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6 Charlesbrooke Rd. Baltimore, Md. 21212  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dulaney Valley Cem. 4-25-96   |  | 20c. LOCATION — City or Town, State<br>Timonium, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson F.H.<br>1050 York Rd. Towson, Md. 21204  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arrhythmia<br>DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D-09383   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/24/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles O'Donnel, MD. 111 Hamlet Hill Rd. Balt. Md. 21210   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 26 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 12465

|   |  |   |  |   |   |  |   |   |  |
|---|--|---|--|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles R Ermer</b>   |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>29</b> Year <b>1996</b> |  | 3. Time of Death<br><b>2:20 am</b>                            |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Meridian- Cromwell Nursing Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baynesville</b>            |  | 4c. County of Death<br><b>Baltimore</b>                       |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-07-3365</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>October 8, 1907</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                       |  | 10c. City, Town or Location<br><b>Overlea</b>                 |   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>4715 Raspe Avenue</b>  |   | 10f. Zip Code<br><b>21206</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Blacksmith</b>  |  | 16b. Kind of Business/Industry<br><b>Steel</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John Ermer</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Spann</b>  |   | 19. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Marie E. Smith / Daughter</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. Date<br><b>5/2/96</b>  |   | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |   | 21. Signature of Funeral Service Licensee<br><b>Mark T. Zavoyna</b>   |  |
| 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road Baltimore, Md. 21214</b>   |  | 23a. Pertt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Arteriosclerotic coronary artery disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Marion C. Kowalewski</b>  |  | 29c. License number<br><b>021022</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4-29-96</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marion C. Kowalewski, M.D. 8604 Harford Road Baltimore, Maryland 21234</b> |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>   |  | 32. Registrar's Signature<br><b>Davidson</b>  |  |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

2. The second part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

3. The third part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

4. The fourth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

5. The fifth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 12466

Reg. No.

|  |   |                      |  |   |  |  |  |  |   |  |  |
|--|---|----------------------|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALFRED C. EZE                                     |                      |  |   | 2. Date of Death<br>Month Day Year<br>APRIL 20, 1996   |  | 3. Time of Death<br>20:08 P  |  |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>2301 MARYLAND AVE. APT. 102 |                      |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A   |  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>Unknown  |                      | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>39 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 6, 1956  |  | 9. Birthplace (State or Foreign Country)<br>Nigeria |  |  |
|  | Usual Residence of Decedent   |                      |  |   |  |  |  |  |   |  |  |
| 10a. State<br>Texas  |   | 10b. County<br>Ector |  | 10c. City, Town or Location<br>Odessa   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br>213 Bunche Avenue  |   |                      |  | 10f. Zip Code<br>79763-5601   |  |  | 10g. Citizen of What Country?<br>USA   |  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4   |   |                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman |  |  | 16b. Kind of Business/Industry<br>Car Dealership   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Unknown   |   |                      |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Vickie K. Eze/wife   |   |                      |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>213 Bunche Avenue Odessa, Texas 79763-5601  |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.  |   |  | Date<br>04/26/96   |  | 20c. Location - City or Town, State<br>Baltimore, MD   |   |  |  |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald   |   |                      |  |   | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Contact gunshot wound of head (intra-cranial)<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |                      |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                      |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                      |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) APT. |   |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |                      | 28a. Date of Injury (Month, Day, Year)<br>UNK  |   | 28b. Time of Injury<br>UNK M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>Shot self      |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Home   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>2301 Maryland Ave Apt. 102 |  |  |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |   |                      |  |   | 29c. License number<br>OCME  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 21, 1996  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>111 Penn Street, Baltimore, Maryland 21201   |   |                      |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |   |                      |  |   | 32. Registrar's Signature<br>[Signature]   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12467

## Certificate of Death

Reg. No.

|  |  |  |  |   |   |   |                                 |   |  |  |
|--|--|--|--|---|---|---|---------------------------------|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SHIRLEY MARIE ELLIOTT</b>                       |  |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> Year <b>1996</b> |   |                                 |   | 3. Time of Death<br><b>10:00 PM</b>            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey Hospice</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |   |                                 |   | 4c. County of Death<br><b>N/A</b>              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-36-5199</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.                      |   | If Under 1 Year<br>Months Days  |   | If Under 24 Hrs.<br>Hours Min.                 |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>April 10, 1939</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Edgemere</b> |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2213 Lincoln Avenue</b>  |   | 10f. Zip Code<br><b>21219</b>   |                                 | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> College (1-4or 5+)  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John Sigai</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosalie Hoerner</b>   |                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Lee Elliott, Sr.</b>   |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2213 Lincoln Avenue Baltimore, Maryland 21219</b>                          |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>04/27/96 Baltimore, Maryland</b>  |                                 | 21. Signature of Funeral Service Licensee<br><b>E. Reed</b>   |  |  |
| 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory Arrest</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>minutes</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |                                 | 28a. Date of Injury (Month, Day, Year)  |  |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                 | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |
| 29b. Signature and title of certifier<br><b>Robert C. Irwin MD</b>   |  | 29c. License number<br><b>208900</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-24-96</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert C. Irwin MD 828 N. Euteraw St. Baltimore MD 21201</b>   |                                 | 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>   |  |  |
| 32. Registrar's Signature<br><b>Julia Davidson</b>   |  |  |  |   |   |   |                                 |   |  |  |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12468

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |                                |  |   |
|---|---|--|---|--|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD FLANNERY</b>   |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>25</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>11:00 AM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>  |                                | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-01-3806A</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Feb 15, 1899</b>   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>A.A.</b>  |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>121 OLEN DRIVE</b>   |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |                                |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRINTER</b>   |  | 16b. Kind of Business/Industry<br><b>CORRUGATED BOXES</b>   |                                |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>MICHAEL FLANNERY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELLA GERLACH</b>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>IDA J. HALL</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>121 OLEN DRIVE, GLEN BURNIE, MD 21061</b>   |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEM.</b>   |  | Date<br><b>4/27/96</b>  |                                | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service licensee<br><i>Thomas J. Skandis</i>   |  | 22. Name and Address of Facility<br><b>RAYMOND C. FINK FUNERAL HOME</b><br><b>426 CRAIN HWY, SW, GLEN BURNIE, MD 21061</b>  |  |   |                                |  |   |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>Congestive heart failure</b><br>Due to (or as a consequence of):  |  |   |                                | Approximate Interval Between Onset and Death<br><b>2 weeks</b>   |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |  | b. <b>Aortic stenosis</b><br>Due to (or as a consequence of):   |  |   |                                | <b>2 years</b>   |   |
| To Be Completed by Physician/Medical Examiner | c.  |  | Due to (or as a consequence of):  |  |   |                                |  |   |
|   | d.  |  | Due to (or as a consequence of):  |  |   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |   |  |   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| To Be Completed by Physician/Medical Examiner |   |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Skandis</i>   |  |   |                                |  |   |
|   |   |  | 29c. License number<br><b>D26307</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/25/96</b>   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>325 Hospital Dr. Rm 201 Glen Burnie md. 21061</b>  |  |   |  |   |                                |  |   |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>   |  |   |  |   |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12469

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William D. Griffin

2. Date of Death

Month 4 Day 26 Year 96

3. Time of Death

1539

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Univ of Maryland Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-44-9808

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 14, 1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3007 MAYFIELD AVE.

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11TH

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

AUTO-DETAILER

16b. Kind of Business/Industry

AUTO

17. Father's Name (First, Middle, Last)

GILES GRIFFIN

18. Mother's Name (First, Middle, Maiden Surname)

MOLLIE BROWN

19a. Informant's Name/Relationship (Type, Print)

ESTELLE C. BROOKS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8734 ROSE LAKE JESSUP MD, 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEM. TK 5/1/96 BARTLETTOWN MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Funeral Home

GARY P. MARCH FUNERAL HOME P.A.  
270 FREDERICK PASS BALT. MD. 21229

23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intraventricular Hemorrhage

24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypertension, IV Drug Use

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Neurosurgeon

29c. License number

06614

29d. Date signed (Month, Day, Year)

4/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Doherty, 22 S Greene St, Balt, MD 21201

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12470  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Junius Grant, Jr.

2. Date of Death

April 24, 1996

3. Time of Death

8:33 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219 50 0815

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/2/1948

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

M.D.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

210 N. CAREY STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12THCollege (1-4 or 5+)  
2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MEDICAL CLERK

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

GEORGE JUNIUS GRANT, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ARDELIA CARROLL

19a. Informant's Name/Relationship (Type, Print)

MRS. ARDELIA CARROLL (MOTHER) 3600 W. FRANKLIN ST. APT. 8J BALTO., MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK 4/30/96 BALTO., MD.CO.

21. Signature of Funeral Service Licensee

LEWIS T. GWYNN

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215  
4517 PARK HEIGHTS AVE. BALTO., MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multifocal Bronchopneumonia

a. Due to (or as a consequence of):

Multicentric Skin

b. Due to (or as a consequence of):

Visceral Kaposi's Sarcoma

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immunodeficiency Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Ganesh Prasad

29c. License number

89260

29d. Date signed (Month, Day, Year)

April 25, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ganesh Prasad, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12471

## Certificate of Death

Reg. No.

|  |  |                                       |   |   |  |  |  |  |  |  |
|--|--|---------------------------------------|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Charlotte Ruth Glick                       |                                       |   |   |  |  | 2. Date of Death<br>Month Day Year<br>April 28, 1996   |  | 3. Time of Death<br>5:30 am                          |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>2602 Gage Ct. Apt. F |                                       |   |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore      |  | 4c. County of Death<br>City                          |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-20-5885   |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 18, 1927   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|  | Usual Residence of Decedent  |                                       |   |   |  |  |  |  |  |  |
| 10a. State<br>Md.  |  | 10b. County                           |   | 10c. City, Town or Location<br>Baltimore  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>2602 Gage Ct. Apt. F   |  |                                       |   | 10f. Zip Code<br>21209  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |                                       |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Interior Decorator |  |  | 16b. Kind of Business/Industry<br>Drapery & Decorating |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Marion Guy Blizzard, Sr.  |  |                                       |   |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br>Glenna R. Wilhide  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Fran Phillips  |  |                                       |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rd. #3 Box 3368 Spring Grove, Pa. 17362 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Evergreen Mem. Gardens Apr. 30, 1996 Finksburg, Md.   |  | 20c. Location - City or Town, State  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>H.G. Eckhardt   |  |                                       |   | 22. Name and Address of Facility<br>Eckhardt Funeral Chapel 21117<br>11605 Reisterstown Rd., Owings Mills, Md.                  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                                       |   |   |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. CANCER BLADDER<br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   |  |                                       |   |   |  |  |  |  |  |  |
| 23b. Dtd tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |                                       |   |   |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |   |   |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                       |   |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |   |   |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |                                       |   |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                       |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |  |                                       |   | 29c. License number<br>035606   |  | 29d. Date signed (Month, Day, Year)<br>4/29/96   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Samuel Zyglis - 21 CROSSROADS DR. #415 OWINGS MILLS, MD. 21117   |  |                                       |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  |                                       |   |   | 32. Registrar's Signature<br>[Signature]   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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ITEMS: 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene  
FILM G-735 5/2/96 t.t

96 12472

## Certificate of Death

Reg. No.

|  |  |  |   |                                |   |
|--|--|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD James GROVES, Sr.</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 23 1996</b>  |                                | 3. Time of Death<br><b>2:23 P.M.</b>  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>UNION MEMERIAL HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death   |
| Funeral<br>Director  | 5. Social Security Number<br><b>189-36-2415</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 19, 1946</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |                                |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |   |                                |   |
|  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Dundalk</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>1957 Church Road</b>  |  | 10f. Zip Code<br><b>21222</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam</b>  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>Collega (1-4or 5+)  |                                |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Caretaker - Golf Course</b>  |  | 16b. Kind of Business/Industry<br><b>Maintenance - Sports</b>   |                                |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frederick Cecil Groves</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Melinda Goodrich</b>  |                                |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan L. Donnelly (Sister)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1957 Church Road Dundalk, Maryland 21222</b>  |                                |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore National Cemetery 4/29/96</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>Johnny L. Gable</b>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>   |                                |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                |   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>   |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
| State<br>Registrar   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                |   |
|  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1996</b>  |
|  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |                                |   |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>  |  |   |                                |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12473

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Sara Jessica Hopkins</b>  |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>'96</b>   |  |  | 3. Time of Death<br><b>5:30 p.m.</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |  | 4c. County of Death  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>N/A</b>  |  | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>N/A</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 26 '96</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent  |  |   | 10a. State<br><b>MD</b>  |  |  | 10b. County<br><b>AAco.</b>  |   |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 10e. Street and Number<br><b>817 Bent Willow DR</b>  |   |  |
|  | 10f. Zip Code<br><b>21061</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>N/A</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |  |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Francis T. Becker II</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>STEPHANIE Hopkins</b>  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane Hopkins Grandparent</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>817 Bent Willow DR Glen Burnie MD 21061</b>  |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill</b>  |  |  | 20c. Location - City or Town, State<br><b>April 30 Anne Arundel Co.</b>  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |   | 22. Name and Address of Facility<br><b>Raymond C. Fink Funeral Home<br/>426 Capin Hwy SW Glen Burnie MD 21061</b>  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Extreme Prematurity, 23 weeks female 1 hr. 30 min.</b> |  |   | Approximate Interval Between Onset and Death   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of injury (Month, Day Year)   |  |  | 28b. Time of injury<br><b>M</b>  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  | 28d. Describe how injury occurred   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. |  |  | 29b. Signature and title of certifier<br><b>Laurel G. Yapp, M.D. Neonatologist</b>  |  |  | 29c. License number<br><b>D29004</b>   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>April 29, 1996</b>   |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LAUREL G. YAPP, M.D. 3001 S. Hanover St. Baltimore, MD 21225</b>   |  |  |  |  |   |  |
| 31. Data filed (Month, Day, Year)<br><b>APR 26 1996</b>  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





96 12474

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12476

## Certificate of Death

Reg. No.

|   |  |   |  |                                      |  |  |   |  |  |  |   |
|---|--|---|--|--------------------------------------|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Willie Gerald Hudson</b>  |   |  |                                      | 2. Date of Death<br>Month <b>Apr.</b> Day <b>23</b> Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>10:35 am</b>                          |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2422 Plainfield Road</b>  |   |  |                                      | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  |   |  | 4c. County of Death<br><b>Baltimore</b>                      |  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>412-38-9012</b>  |   | 6. Sex<br><b>1</b> M <b>2</b> F  |                                      | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 7, 1927</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b> |  |   |
|   | Usual Residence of Decedent  |   |  |                                      | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>                |  |   |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>2422 Plainfield Road</b>  |   |  |                                      | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |  |  |   |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>1945-1947</b>          |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 years</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b> |                                      | 16b. Kind of Business/Industry<br><b>Steel Industry</b>  |  |   |  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Leo Hudson</b>   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeannie Ball</b>   |  |   |  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ida E. Hudson (Wife)</b>  |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P. O. Box 498 Riderwood, Maryland 21139</b>                                  |  |   |  |  |  |   |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens</b>                        |                                      | Date<br><b>4/26/96</b>   |  | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>         |  |  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Chad W. Lutz</i>   |   |  |                                      | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b><br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>  |  |   |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Respiratory arrest</b><br>Due to (or as a consequence of):<br><b>b. COPD</b><br>Due to (or as a consequence of):<br><b>c. Influenza LLL</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |                                      | Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>years</b><br><b>2 wk.</b>   |  |   |  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |                                      | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |   |  |  |  |   |
|   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   |  |                                      | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day, Year)                        |  | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No       |   | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>John O. Davis</i> |  | 29c. License number<br><b>D18648</b> |  | 29d. Date signed (Month, Day, Year)<br><b>24/23/96</b> |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>10.12.022 N. Pt. D. Brittanne mil 21224</b> |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>   |  | 32. Registrar's Signature<br><i>John O. Davis</i>             |  |                                      |  |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10-1

11

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methods used in the study. The fourth part is a presentation of the results, and the fifth part is a conclusion and discussion of the findings.

The results of the study show that there is a significant difference between the two groups. The first group, which received the treatment, showed a higher level of performance than the second group, which did not receive the treatment. This difference was statistically significant at the 5% level. The results also show that the treatment had a positive effect on the performance of the first group.

The conclusion of the study is that the treatment is effective in improving the performance of the first group. This finding has important implications for the field of research. It suggests that the treatment can be used to improve the performance of other groups. The study also has some limitations, which are discussed in the discussion section. These limitations include the small sample size and the lack of a control group. Despite these limitations, the study provides valuable information about the effectiveness of the treatment.

12

96 12477

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ida A. Hoff</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>24</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>5:55 A.</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-12-9241</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 13, 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Penna.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridan Franklin Woods</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>N/A</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5909 Bertram Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21214</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel G. Hoff</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary F. Brumbaugh</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert A. Brumbaugh</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RR 2 Box 9225 Milford, Penna. 18337</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holsinger Cemetery 4/29/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baker Summit, Penna.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Milton J. Knight Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road Baltimore, Md. 21214</b>   |  |  |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic Colon Carcinoma</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard A. Huslig, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D36814</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/29/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard A. Huslig, M.D. 7505 Osler Drive, Towson, Maryland 21204</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 26 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12478

ITEM#19B film g734 4/29/96ag perFH Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|---|--|--|---|--|--|--|--|--|---|----|-----------------------------|--|----|--------|--------|----|---------------|----------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARVIN JOSEPH JACKSON  |  |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 25, 1996   |  | 3. Time of Death<br>12:45 pm                                     |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>818 S. COLLINGTON AVENUE   |  |   |  | 4b. City, Town, or Location of Death<br>baltimore city   |  | 4c. County of Death<br>n/a                                       |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-64-1552   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>41 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JAN. 22, 1955             |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 9. Birthplace (State or Foreign Country)<br>BALTIMORE, MD  |  | 10a. State<br>MD  |  | 10b. County<br>n/a   |  | 10c. City, Town or Location<br>BALTIMORE                         |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 10e. Street and Number<br>400 ATHOL AVENUE   |  |   |  | 10f. Zip Code<br>21229   |  | 10g. Citizen of What Country?<br>UNITED STATES                   |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 <sup>th</sup> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer - unemployed                     |  | 16b. Kind of Business/Industry<br>various  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 17. Father's Name (First, Middle, Last)<br>OTHA HOLLAND  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FRANCIS REGINA JACKSON  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>HELEN JACKSON  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>400 ATHOL AVENUE, BALTIMORE, MD 21229   |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GREENMOUNT CREMATORY  |  | 20c. Location - City or Town, State<br>BALTIMORE, MD   |  | 20d. Date<br>4-30  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 21. Signature of Funeral Service Licensee<br>Vanessa Cost  |  |   |  | 22. Name and Address of Facility<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>SEPSIS</td> <td>1 week</td> </tr> <tr> <td>c.</td> <td>HIV INFECTION</td> <td>10 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | ACUTE MYOCARDIAL INFARCTION | Approximate Interval Between Onset and Death | b. | SEPSIS | 1 week | c. | HIV INFECTION | 10 years | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.   | ACUTE MYOCARDIAL INFARCTION            | Approximate Interval Between Onset and Death  |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | b.   | SEPSIS                                 | 1 week  |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | c.   | HIV INFECTION                          | 10 years  |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   | d.   |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
|   |  | 28d. Describe how injury occurred      |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 29b. Signature and title of certifier<br>Kongsak Chantornsaeng, M.D.  |  |  |   | 29c. License number<br>PO - 9145   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 29, 1996                                |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>KONGSAK CHANTORNSEANG, M.D. ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MD   |  |  |   |  |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996  |  |  |   | 32. Registrar's Signature<br>John Davidson Randall                                     |  |  |  |  |   |    |                             |  |    |        |        |    |               |          |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Z

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 12479

Reg. No.

|   |   |  |   |   |   |  |   |  |  |
|---|---|--|---|---|---|--|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>FREDERICK SMITH KNABE</b>                            |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 27, 1996</b>   |  | 3. Time of Death<br><b>5:30 A.M.</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b> |  | 4c. County of Death<br><b>N/A</b>   |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>213-09-3515</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.              |  | 8. Date of Birth (Month, Day, Year)<br><b>July 16, 1914</b>                                 |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  | 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>                               |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW-II</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Superintendent</b>  |   |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel Corp.</b>                              |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest F. Knabe</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna S. Klingelhofer</b>  |   |  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Elizabeth P. Knabe</b> |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8800 Walther Blvd. Baltimore, Md. 21234 #2212</b>   |   |  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>5/1/96 Pikesville, Md.</b>               |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)<br/><b>Multiple System Organ Failure</b></p> <p>Due to (or as a consequence of):<br/><b>Ischemic Bowel sp. total colectomy</b></p> <p>Due to (or as a consequence of):<br/><b>Atherosclerosis</b></p> <p>Due to (or as a consequence of):<br/><b>Coronary Artery Disease sp. coronary artery bypass</b></p> </div> <div style="width: 15%; text-align: center;"> <p><b>48 hours</b></p> <p><b>72 hours</b></p> <p><b>15 years</b></p> <p><b>8 days</b></p> </div> </div> |   |  |   |   |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Lung Cancer</b>  |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                               |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |  | 29c. License number<br><b>610884</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>April 27, 1996</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gretchen M. Alverdt MD Johns Hopkins Hospital 600 N. Wolfe St Baltimore MD 21205</b>   |   |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>   |   |  | 32. Registrar's Signature<br>   |   |   |  |   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

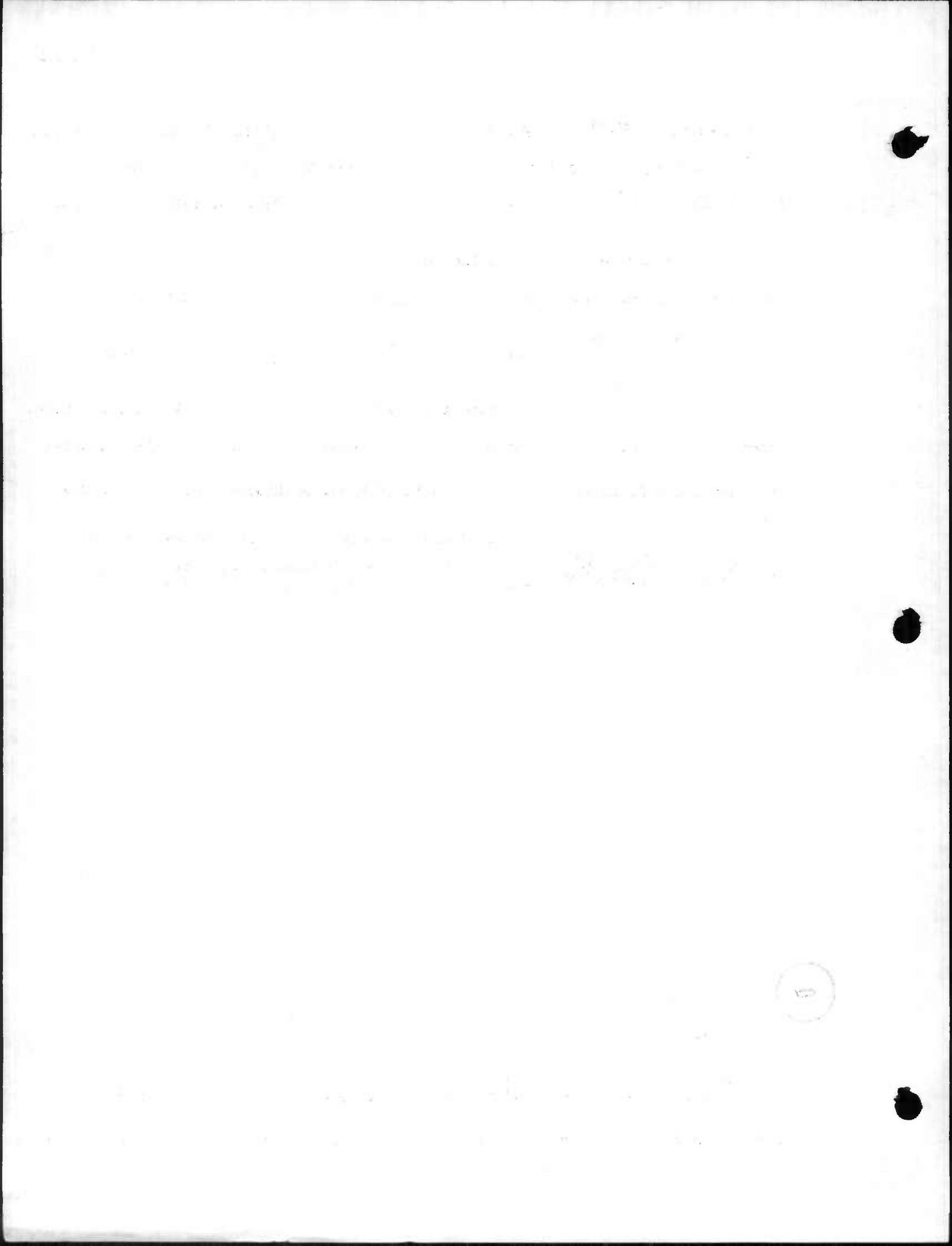
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar

12 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 12480

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |   |  |
|--|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hilda Maxine Krimmelbein                 |   |  |  | 2. Date of Death<br>Month Day Year<br>April 29, 1996 |  | 3. Time of Death<br>7:00am                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>2604 Myrtle Avenue |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore    |  | 4c. County of Death<br>Baltimore                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-18-6926   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>71 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>July 1, 1924 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland                                 |   | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore                             |  | 10c. City, Town or Location<br>Baltimore            |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>2604 Myrtle Avenue  |  | 10f. Zip Code<br>21227   |  | 10g. Citizen of What Country?<br>USA   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4 or 5+) 11  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk  |  | 16b. Kind of Business/Industry<br>Laundromat   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Norman Gerald Reinhardt   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Delmar Ann Connelly   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lawrence Reinhardt Shipley/son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 89 Savage, MD 20763  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.   |  | 20c. Date<br>04/30/96  |  | 20d. Location - City or Town, State<br>Baltimore, MD   |   |  |
| 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald  |  |   |  | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Ischemic Cardiovascular</u><br>Due to (or as a consequence of):<br>b. <u>Old Myocardial Infarction</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |
| Approximate Interval Between Onset and Death<br>3 years<br>3 years   |  |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Jeffrey J. Rubin MD  |  | 29c. License number<br>D21512  |  | 29d. Date signed (Month, Day, Year)<br>April 29, 1996  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>3449 W. Hens Avenue Balt Md, 21229   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12481

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |  |  |
|--|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Charles A. Kennedy, Jr.</i>                           |   |  |  | 2. Date of Death<br>Month <i>4</i> Day <i>27</i> Year <i>96</i> |   | 3. Time of Death<br><i>12:40 PM</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Baltimore VA Medical Center</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>        |   | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>220-03-5995</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><i>84</i>  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><i>SEPT 16, 1911</i>   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>    |
|  | Usual Residence of Decedent  |   |  |  |   |   |  |  |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Baltimore</i>   |  | 10c. City, Town or Location<br><i>Catonsville</i>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><i>40 Ridge Road</i>   |  |   |  | 10f. Zip Code<br><i>21228</i>  |   | 10g. Citizen of What Country?<br><i>USA</i>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>WW II / Korean Conflict</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Guard</i>  |   | 16b. Kind of Business/Industry<br><i>Penitentiary</i>                                       |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Charles Arthur Kennedy</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Edith Engelhaupt</i>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Edith Patricia Kennedy/Sister</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>40 Ridge Road Catonsville, MD 21228</i>  |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Metro Crematory, Inc. 4/29/96</i>   |   | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>                                 |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Dawn F. McDonald</i>   |  |   |  | 22. Name and Address of Facility<br><i>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</i>   |   |   |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <i>Sepsis</i><br>Due to (or as a consequence of):  |  |  |   |   |  | Approximate Interval Between Onset and Death<br><i>2 weeks</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. <i>Dementia</i><br>Due to (or as a consequence of):  |  |  |   |   |  | <i>2 years</i>   |
|  |  | c. <i>Anasarca</i><br>Due to (or as a consequence of):  |  |  |   |   |  | <i>2 months</i>  |
|  |  | d.  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                              |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |   |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Kenneth Yin MD</i>  |  | 29c. License number<br><i>P07770</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>4/27/96</i>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Kenneth Yin, University of MD Hospital, 225. Greene St, Baltimore</i>   |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 29 1996</i>  |  | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 12482

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>REGINA C. KRAUS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>25</b> YEAR <b>1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>12 40 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 01 0595</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____             |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 24, 1903</b>  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland Manor Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7955 Queens Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21061</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>         |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) _____   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Cornelius Reilly</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maria Gilboy</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ronald Kraus</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7955 Queens Road Glen Burnie, Maryland 21061</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Louisa Park Cemetery</b>   |  | DATE<br><b>4/29</b>                                    |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George J. Gonce</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>  |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CORONARY ARTERY DISEASE</b> 10 years<br>DUE TO (OR AS A CONSEQUENCE OF): <b>ESSENTIAL HYPERTENSION</b> 18 years<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>ANAEMIA NORMOYTIC NORMOCHROMIC</b> 5 years<br>DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b> 3 years |  |  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CEREBRAL VASCULAR INSUFFICIENCY</b><br><b>BLINDNESS</b>  |  |  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Harjit Singh M.D.</i> <b>ATTENDING PHYSICIAN</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 14160</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04-25-96</b> |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY BALTIMORE MARYLAND 21225</b>   |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12483

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br><b>Aleksy Kowalewski</b>   |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>2:09 PM</b>   |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>1307 Judges Court</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |  | 4c. County of Death<br><b>Carroll</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>080-20-1358A</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>01/10/1922</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>Poland</b> |  |
|  | Usual Residence of Decedant  |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>  |   | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>1307 Judges Court</b>   |   |   |  | 10f. Zip Code<br><b>21784</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedant Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |   |   |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steelworker</b>  |  | 16b. Kind of Business/Industry<br><b>Steel</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Tomasz Kowalewski</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Paulina Taborowska</b>   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nina Roscoe Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1307 Judges Court Sykesville, Md 21784</b>   |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Memorial Park</b>  |  | Date<br><b>4/30</b>  |  | 20c. Location - City or Town, State<br><b>Marriottsville, Md</b>                               |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>David J. Weber Funeral Home<br/>401 S. Chester Street Baltimore, Maryland 21231</b>   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>hepatic failure</b><br>Due to (or as a consequence of):<br>b. <b>chronic hepatitis B</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>he had a colon resection for carcinoma late last year - there was a question of liver metastasis at the time.</b>   |  |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   |  |  |  |  |   |  |
| 29c. License number<br><b>D34406</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/29/96</b>   |   |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Richmond P. Allen, 1645 Liberty Rd., Eldersburg, MD 21784</b>   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12484

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DENISE GEORGETTE LAMOT

2. Date of Death

Month Day Year

April 26, 1996

3. Time of Death

8:33 AM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare-Randallstown

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

354-48-2041

8. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 30, 1953

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Upperco

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

14625 Hanover Road

10f. Zip Code

21155

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Newspaper Reporter

16b. Kind of Business/Industry

Publications

17. Father's Name (First, Middle, Last)

George Lamot

18. Mother's Name (First, Middle, Maiden Surname)

Renee Barski

19a. Informant's Name/Relationship (Type, Print)

Lynette F. Klemm

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

802 Van Dyke Lane Bel Air, Maryland 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

4/29/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

John Z. Steele

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Multiple sclerosis

History of Seizures

recurrent urinary tract infections

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Lewin MD

29c. License number

D27075

29d. Date signed (Month, Day, Year)

4/26/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Claudio Levin MD 10219 S. Dr./field Rd. Dundalk, MD 21117

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Karlson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12485

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lulu Knott McIntyre

2. Date of Death

Month Day Year  
April 25 1996

3. Time of Death

11<sup>39</sup>/Am

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

579-24-3091

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 8, 1922

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belair

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Ponderosa Drive

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

Knott

18. Mother's Name (First, Middle, Maiden Surname)

Unknown Stillwell

19a. Informant's Name/Relationship (Type, Print)

Mrs. G. Sue Wells - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12703 Lee Ben Road -Kingsville Maryland 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

4/29/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.  
5305 Harford Road - Baltimore Maryland 21214

23a. Part I. Enter the disease, or conditions, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Cardiac Arrest  
Due to (or as a consequence of):

b. Acute Myocardial Infarction  
Due to (or as a consequence of):

c. Ischemic Heart Disease  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 hour

2 years

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D23519

29d. Date signed (Month, Day, Year)

April 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Smith MD

Fallston General Hospital

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12486

## Certificate of Death

Reg. No.

|  |   |                                 |   |   |  |   |   |   |   |                                   |  |
|--|---|---------------------------------|---|---|--|---|---|---|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LINDA MAY MEZOFF</b>                                       |                                 |   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 23, 1996</b> |   | 3. Time of Death<br><b>2:00PM</b>                                       |                                   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |                                 |   |   |  |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>       |   | 4c. County of Death<br><b>BALTIMORE</b>                                 |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-32-8790</b>   |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>5-27-1935</b>     |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |                                   |  |
|  | Usual Residence of Decedent   |                                 |   |   |  |   |   |   |   |                                   |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Towson</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                   |  |
| 10e. Street and Number<br><b>942 Dulaney Valley Road, Apt 1</b>  |   |                                 |   | 10f. Zip Code<br><b>21204</b>   |  |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Photo Type Setter</b>   |  |   |   | 16b. Kind of Business/Industry<br><b>Baltimore County School</b>  |   |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wallace Edward Dize</b>  |   |                                 |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dulce D. Crow</b>   |   |   |   |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Mezoff, Jr. (Husband)</b>   |   |                                 |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>942 Dulaney Valley Road, Apt 1 Towson, Maryland</b>                                       |   |   |   |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery 4-27-96</b>  |  |   |   | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>   |   |                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>Wallace S. Brooks, Jr.</b>   |   |                                 |   |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md. 21204</b>   |   |   |   |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>immediata Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>Nasopharyngeal Cancer</b><br/>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death<br/><b>4 mos</b></p> </div> </div> |   |                                 |   |   |  |   |   |   |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                 |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |                                   |  |
|  |   |                                 |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                   |  |
|  |   |                                 |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |   |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                                 |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred |  |
|  |   |                                 |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                                 |   |   |  |   |   |   |   |                                   |  |
| 29b. Signature and title of certifier<br><b>Paul C. [Signature]</b>  |   |                                 |   |   |  | 29c. License number<br><b>D30529</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/23/96</b>   |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul C. [Signature], MD 6569 N. Charles St, Baltimore MD 21204</b>  |   |                                 |   |   |  |   |   |   |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>  |   |                                 |   | 32. Registrar's Signature<br><b>Julia [Signature]</b>   |  |   |   |   |   |                                   |  |

Baltimore, Maryland 21215-0020

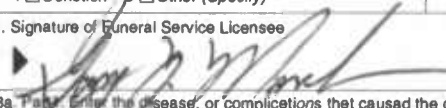
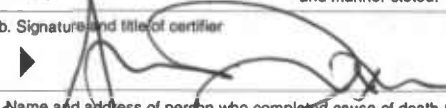
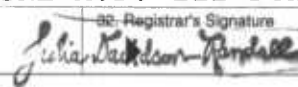
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 12487

Reg. No.

|   |  |  |   |  |   |  |  |                                    |  |  |
|---|--|--|---|--|---|--|--|------------------------------------|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIE MCGOWAN</b>  |  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 22, 1996</b>  |  | 3. Time of Death<br><b>2:20 PM</b> |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4214 LOCH RAVEN BLVD.</b>   |  |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>244-36-1983</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.                             | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 2, 1932</b>                                     |                                    | 9. Birthplace (State or Foreign Country)<br><b>S. CAROLINA</b> |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |  |                                    |  |  |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |  |
|   | 10e. Street and Number<br><b>4214 LOCK RAVEN BLVD.</b>   |  |   |  | 10f. Zip Code<br><b>21218</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |                                    |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year(s)<br><b>Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |                                    |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                                 |  |   | 16b. Kind of Business/Industry<br><b>STADIUM</b>   |  |                                    |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WILLIE MC GOWAN</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>WILLIE MAE LEAKS</b>   |  |                                    |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><b>WILLIE MAE TOWNSEND</b>   |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>812 EAST JERSEY ST. ELIZABETH N.J. 07201</b> |  |                                    |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROSEDALE</b>   |  | 20c. Location - City or Town, State<br><b>4/27/96 LINDEN N.J</b>  |  | 20d. Location - City or Town, State<br><b>270 FRED HILTON DR. BALT. MD. 21229</b>              |                                    |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  |   | 22. Name and Address of Facility<br><b>GARY P. MARCH FUNERAL HOME P.A. 270 FRED HILTON DR. BALT. MD. 21229</b>                                   |  |                                    |  |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |   |  |   |  |  |                                    |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |  |                                    |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |                                    |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |  |  |                                    |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                           |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |                                    |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>   |                                    | 29d. Date signed (Month, Day, Year)<br><b>APRIL 29, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON LOCKE M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |   |  |  |                                    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>   |  | 32. Registrar's Signature<br> |   |  |   |  |  |                                    |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 12488

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNE Elizabeth ORENDORFF

2. Date of Death

Month Day Year  
APRIL 20 1996

3. Time of Death

1:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-28-3022

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 2, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3806 Parkmont Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Proprietor

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Harry V. Eckenrode

18. Mother's Name (First, Middle, Maiden Surname)

Rose C. Anthony

19a. Informant's Name/Relationship (Type, Print)

Mr. Laurence F. Orendorff / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3806 Parkmont Avenue Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Cemetery

Date

5/1/96

20c. Location - City or Town, State

Emmitsburg, Maryland

21. Signature of Funeral Service Licensee Mark T. Zavoyna

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Md. 21214

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ENDSTAGE CHRONIC LUNG DISEASE

Due to (or as a consequence of):

Approximate interval between Onset and Death

yrs.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia, Alzheimer's-type

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kendall R. Faulkner

29c. License number

D05643

29d. Date signed (Month, Day, Year)

4/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kendall R. Faulkner, M.D. 2300 Dulany Valley Road Towson, Md. 21204

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Julia Davidson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12489

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CALVIN LEE PROPPS</b>                               |  |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>27</b> Year <b>1996</b> |  | 3. Time of Death<br><b>4:45 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>           |  | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>233-78-1004</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br><b>48</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 14, 1947</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                   |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>                                       |  | 10c. City, Town or Location<br><b>Reisterstown</b>          |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>121 East Chatsworth Ave.</b>  |  | 10f. Zip Code<br><b>21136</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                   |  | 16b. Kind of Business/Industry<br><b>Paving &amp; Construction</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Larkin Propps</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Verna Crist</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Katharine Lyons</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>121 E. Chatsworth Ave., Reisterstown, Md. 21136</b>                                      |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Clifty Meth. Ch. Cem. May 1, 1996</b>   |  | 20c. Location - City or Town, State<br><b>Hico, West Virginia</b>  |  | 21. Signature of Funeral Service Licensee<br><b>H. J. Eckhardt</b>   |   | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel<br/>11605 Reisterstown Rd., Owings Mills, Md. 21117</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>1 Hour</b>  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  | 29c. License number<br><b>D 47587</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 27, 1996</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT FINE, MD NORTHWEST HOSPITAL CENTER</b>   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  | 33. Registrar's Name<br><b>[Name]</b>  |   | 34. Registrar's Title<br><b>[Title]</b>  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

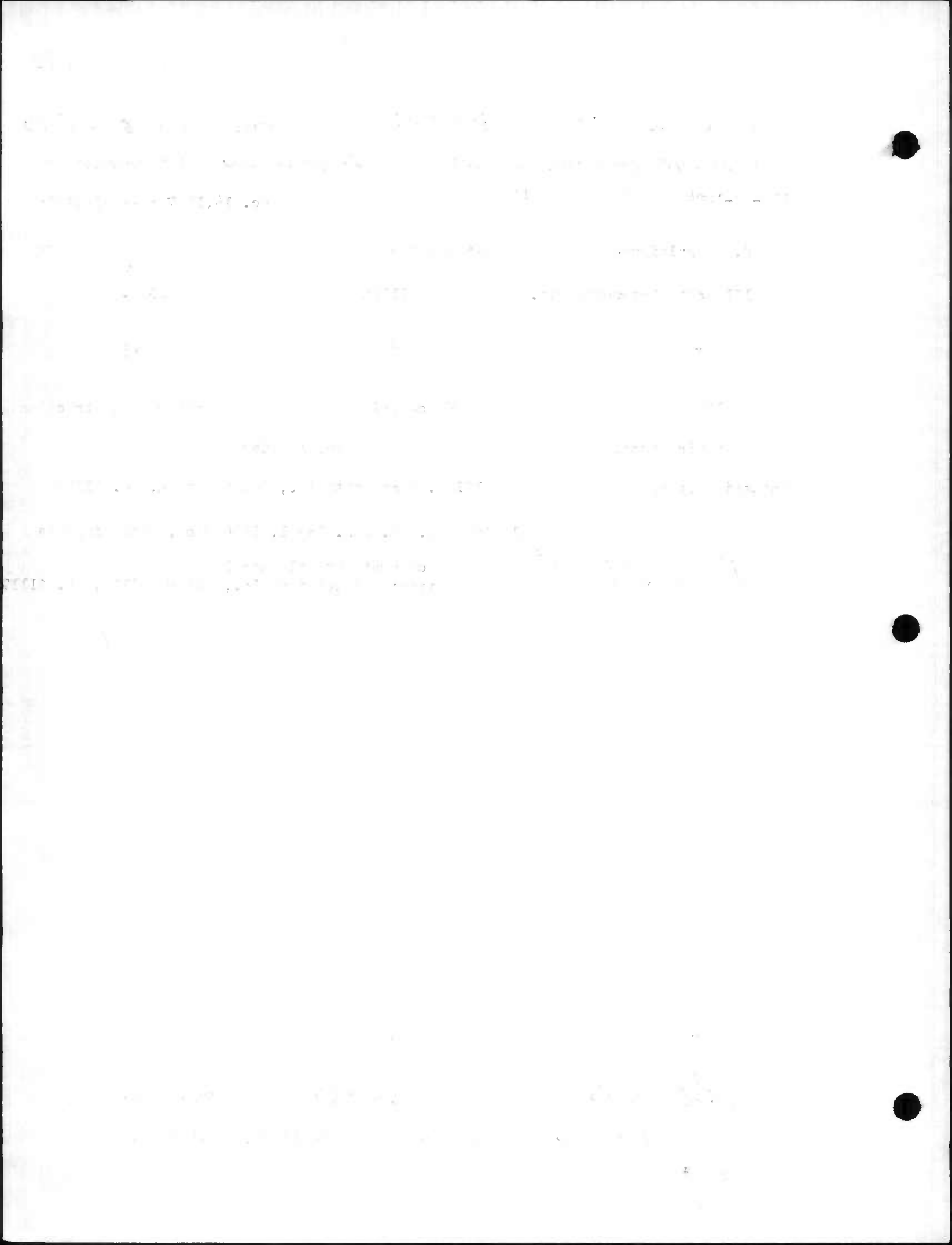
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12





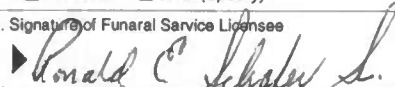
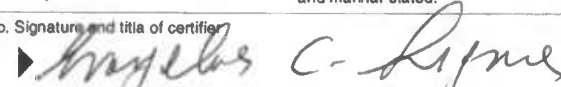
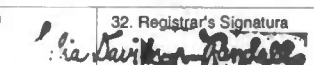
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12490

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES S. PAPPAS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24, 1996</b>  |   | 3. Time of Death<br><b>3:50 P.M.</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. JOSEPH MEDICAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON, MD.</b>   |   | 4c. County of Death<br><b>BALTIMORE</b>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-16-1668</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>February 4, 1923</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>                            |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8619 Wendell Ave.</b>  |  | 10f. Zip Code<br><b>21234</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>                                       |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Samuel Pappas</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Dukas</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Harriet Pappas - Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10e</b>  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Demetrios Cemetery 4/27/96</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home, Inc.<br/>5305 Harford Road - Baltimore, Maryland 21214</b>                                 |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>SEPTIC SHOCK</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>CONGESTIVE HEART FAILURE</b> |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b>  |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>CONGESTIVE HEART FAILURE</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No              |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>019589</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-25-96</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>EVANGELOS LIGNOS, M.D., 7801 YORK ROAD, SUITE 102, TOWSON, MD. 21204</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 1996</b>  |   | 32. Registrar's Signature<br> |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12491

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARION GRACE QUAREGAN

2. Date of Death

Month Day Year  
APRIL 26 1996

3. Time of Death

12 NOON

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bel Air Nursing &amp; Rehab. Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

203-14-9580

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 10, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

616 Woodbine Avenue

10f. Zip Code

21204-3825

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Abraham Weixler

18. Mother's Name (First, Middle, Maiden Surname)

Alberta Strigel

19a. Informant's Name/Relationship (Type, Print)

Jane Webster/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

616 Woodbine Avenue Towson, MD 21204-3825

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

04/27/96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 years

Sequitely list conditions,  
if any, leading to immediate  
Cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28e. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dawn F. McDonald

29c. License number

D08339

29d. Date signed (Month, Day, Year)

APRIL 26, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

101 E. Wheel Road Bel Air, MD 21015

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Julia Sullivan-Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 12492

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James Phillip Ryder</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 27 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>2 45 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>145-12-7316</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>NOV 10, 1923</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |  |  |   |  |  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>6150 Foreland Garth Apt. 213</b>   |  |  |  | 10f. ZIP CODE<br><b>21045</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Foreman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Plastics Factory</b>                        |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Phillip James Ryder</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Nolan</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Blanche Gibbons</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6150 Foreland Garth Apt. 500 Columbia, MD 21045</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of crematory, crematory or other place)<br><b>Metro Crematory, Inc. 4/29/96</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                      |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dawn F. McDonald</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Carcinoma of the lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>000359</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/28/96</b>                            |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>301 ST. PAUL Place Baltimore, Md 21202</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



17-03-38

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12493

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |   |  |  |
|--|--|---|--|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>OLIVE JANE RABER</u>                                      |   |  |   | 2. Date of Death<br>Month <u>April</u> Day <u>27th</u> Year <u>1996</u> |  |  |  | 3. Time of Death<br><u>12:55 pm</u>                         |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><u>Carroll County General Hospital</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Westminster</u>              |  |  |  | 4c. County of Death<br><u>Carroll County</u>                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>129-10-0042</u>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>86</u> Yrs.                        |  | 8. Date of Birth (Month, Day, Year)<br><u>Jan. 7, 1910</u> |  | 9. Birthplace (State or Foreign Country)<br><u>New York</u> |  |  |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |   |  |  |
| 10a. State<br><u>MD</u>  |  | 10b. County<br><u>Carroll County</u>  |  | 10c. City, Town or Location<br><u>Westminster</u>   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |
| 10a. Street and Number<br><u>3271 Sykesville Road</u>  |  |   |  | 10f. Zip Code<br><u>21157</u>   |   |  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>   |   |  |  | 16b. Kind of Business/Industry<br><u>Domestic</u>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Joseph Post Marfing</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>May Ursula (unknown)</u>  |   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Mr. Laurence B. Raber (son)</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3271 Sykesville Road Westminster, MD 21157</u>  |   |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Carroll Cremation Serv.</u>  |  | Date<br><u>4/28/96</u>  |   | 20c. Location - City or Town, State<br><u>Hampstead, MD</u>                          |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Brian R. Haight</u>  |  |   |  | 22. Name and Address of Facility<br><u>HAIGHT FUNERAL HOME (P.O. Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</u>   |   |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <u>Sepsis</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Perforated Duodenal Ulcer</u><br/>Due to (or as a consequence of):</p> <p>c. <u>Acute Abdominal Pain</u><br/>Due to (or as a consequence of):</p> <p>d. <u>Severe Hypocalcemia</u></p> </div> </div> |  |   |  |   |   |  |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Major Depression, Normocytic Anemia,</u><br><u>Peripheral Vascular Disease,</u>   |  |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
|  |  |   |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
|  |  |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |   |  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |   |  | 29c. License number<br><u>D37949</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>April 27th, 1996</u>                       |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><u>Alexander Bogdanovich 1425 Liberty Rd. Suite #208 Eldersburg, MD, 21701</u>   |  |   |  |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1996</u>  |  |   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12494

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |                          |  |  |  |   |  |                                |  |   |  |
|--|--|--|---|--|--|--------------------------|--|--|--|---|--|--------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>IRMA MARIE SMITH   |  |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 26 1996  |                          | 3. Time of Death<br>6:10 A                           |  |  |   |  |                                |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ST. AGNES HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |                          | 4c. County of Death<br>N/A                           |  |  |   |  |                                |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-44-1875   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Oct. 17, 1913 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |  |                                |  |   |  |
|  | Usual Residence of Decedent  |  |   |  |  |                          |  |  |  |   |  |                                |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Catonsville   |                          |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |                                |  |   |  |
|  | 10e. Street and Number<br>49 Dungarrie Road  |  |   |  | 10f. Zip Code<br>21228   |                          | 10g. Citizen of What Country?<br>USA                 |  |  |   |  |                                |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |                                |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retail Clerk  |                          |  | 16b. Kind of Business/Industry<br>Bakery   |  |   |  |                                |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Henry August Kummer, Jr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Louise Kurtz  |                          |  |  |  |   |  |                                |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Kenneth Irvin Smith/son  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>49 Dungarrie Road Catonsville, MD 21228   |                          |  |  |  |   |  |                                |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.  |                          | Date<br>04/27/96                                     |  | 20c. Location - City or Town, State<br>Baltimore, MD   |   |  |                                |  |   |  |
|  | 21. Signature of Funeral Service Licensee Dawn F. McDonald   |  |   |  | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228  |                          |  |  |  |   |  |                                |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                          |  |  |  |   | Approximate Interval Between Onset and Death   |                                |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Clinical Alzheimer's disease</u>  |  |   |  |  |                          |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |                          |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |                          |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   | 28a. Date of Injury (Month, Day, Year)                                       |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |                                |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                          |  |  |  |   |  |                                |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |                          |  |  |  | 29b. Signature and title of certifier<br>Donald G. Wright MD  |  | 29c. License number<br>O.C.M.E |  | 29d. Date signed (Month, Day, Year)<br>APRIL 26, 1996 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |  |  |                          |  |  |  |   |  |                                |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996   |  |  |   |  |  |                          |  |  |  | 32. Registrar's Signature<br>Julia Taylor-Nordella  |  |                                |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



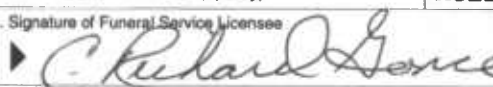
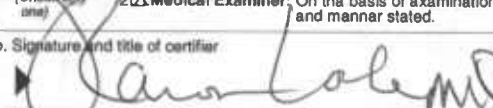
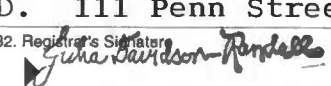
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12495

## Certificate of Death

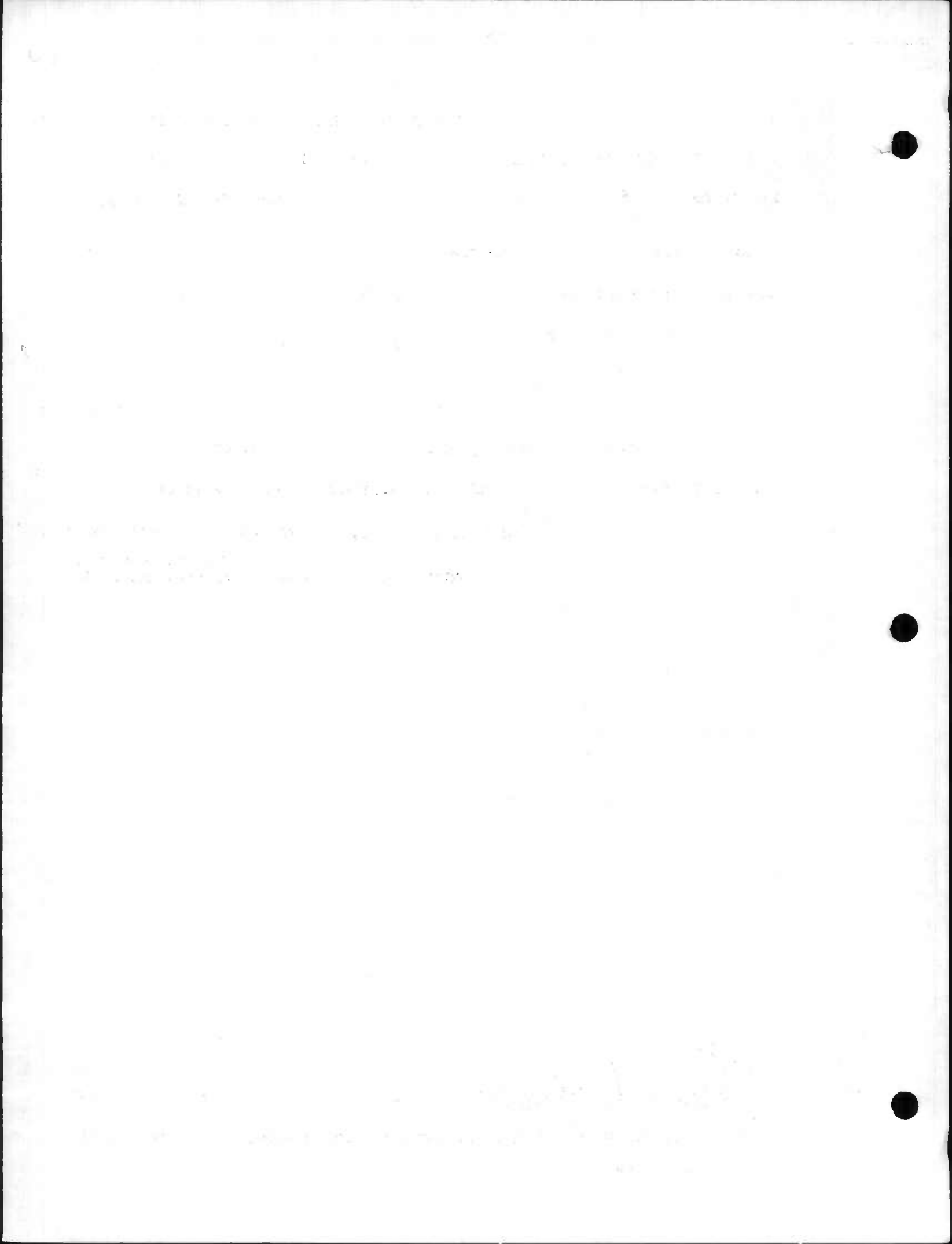
Reg. No.

|   |  |  |   |                                |  |  |
|---|--|--|---|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DONALD J. SLAUBAUGH SR.  |  | 2. Date of Death<br>Month Day Year<br>APRIL 26, 1996  |                                | 3. Time of Death<br>4:03PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>408 SOUTH BENTALOU STREET  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |                                | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director   | 5. Social Security Number<br>220 82 9547   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br>35 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 15, 1961  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |                                |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |                                |  |  |
|   | 10a. State<br>Maryland   |  | 10b. County<br>N/A  |                                | 10c. City, Town or Location<br>Baltimore   |  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                |  |  |
|   | 10e. Street and Number<br>408 South Bentalou Street  |  | 10f. Zip Code<br>21223  |                                | 10g. Citizen of What Country?<br>U.S.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |                                |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collegiate (1-4 or 5+) 1 year   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager  |                                | 16b. Kind of Business/Industry<br>Windshields America  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Vernon E. Slaubaugh Sr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary A. Smith  |                                |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Dawn M. Slaubaugh  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223<br>408 South Bentalou Street Baltimore, Maryland  |                                |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery   |                                | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br> |  | 22. Name and Address of Facility<br>Gonce Funeral Home P.A.<br>4001 Ritchie Highway Baltimore, Md. 21225         |   |                                |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. CONTACT GUNSHOT WOUND OF HEAD<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br>4/26/1996  |                                | 28b. Time of Injury<br>3:30 PM   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>SELF-INFLICTED GUNSHOT WOUND   |                                |  |  |
|   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>408 SOUTH BENTALOU STREET BALTIMORE, MARYLAND  |  |   |                                |  |  |
|   | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |  |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>O.C.M.E.   |                                | 29d. Date signed (Month, Day, Year)<br>APRIL 27, 1996  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. LARON LOCKE M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1996  |  | 32. Registrar's Signature<br> |   |                                |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit certificate.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Leonard Schriefer</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 22 1996</b>   |  | 3. TIME OF DEATH<br><b>7:52 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-09-3895</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 25, 1907</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>1722 Rita Road</b>  |  | 10f. ZIP CODE<br><b>21222</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Balto. County Policeman</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law Enforcement</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Schriefer</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dorthea C. Hillmer</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John A. Schriefer</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10110 Fontaine Drive Baltimore, Maryland 21234</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>4/26/96 Baltimore, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Possible Aspiration</b>  |  | Approximate Interval Between Onset and Death<br><b>1 Day</b>  |  |
|  |  | b. <b>Cardiovascular Disease</b>   |  | <b>5yr+</b>   |  |
|  |  | c. <b>Anoxic Brain Injury</b>  |  | <b>5yr</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | d.   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
|  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Drew C. Fuller M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>96004</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 22, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Drew C. Fuller, M.D. 4940 Eastern Avenue Baltimore, Md. 21224</b>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 26 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

952-7

91

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

12497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ALLAN THOMPSON, Jr.

2. Date of Death

APRIL 26 1996

3. Time of Death

9:00 p.m.

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-20-8637

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 16, 1926

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

17 Anderson Ridge Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Allan Thompson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna M Brundick

19a. Informant's Name/Relationship (Type, Print)

Mrs. Patty J. Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 Anderson Ridge Rd. Catonsville, Md. 21228

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

4/29/96

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

b. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days.

3 years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Adoo MD

29c. License number

D420386

29d. Date signed (Month, Day, Year)

April 26<sup>th</sup> 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLARENCE SARKIS - Adoo MD

ST AGNES HOSP  
900 CATON AVE, BALT MD 21229

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

6. The sixth part of the report is devoted to a detailed analysis of the international situation.

7. The seventh part of the report is devoted to a detailed analysis of the future prospects.

8. The eighth part of the report is devoted to a detailed analysis of the conclusions.

9. The ninth part of the report is devoted to a detailed analysis of the recommendations.

10. The tenth part of the report is devoted to a detailed analysis of the annexes.

11. The eleventh part of the report is devoted to a detailed analysis of the bibliography.

12. The twelfth part of the report is devoted to a detailed analysis of the index.

13. The thirteenth part of the report is devoted to a detailed analysis of the appendices.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>George B. Turner</u> George Brewer Turner   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 24, 1996  |  | 3. TIME OF DEATH<br>11:05 a.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-16-1932   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 72 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>November 5, 1923   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Essex  |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br>RIVERVIEW NURSING CENTRE, INC.   |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>N/A   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>5103 Pembroke Avenue   |  |  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>8 years   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Ship Maintenance  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Thomas Turner   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Fisher  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Naomi E. Turner (Wife)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5103 Pembroke Avenue Baltimore, Md. 21206  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hilltop Service Corp. 4/26/96   |  | 20c. LOCATION — City or Town, State<br>Towson, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Johnny L. Dade</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> Approximate Interval Between Onset and Death <u>1/2 hour</u>   |  |  |  |   |  |   |  |
| b. <u>Sudden Cardiac Death</u> <u>1/2 hour</u>   |  |  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| c. <u>Coronary Artery Disease, Hypertension</u>  |  |  |  |   |  |   |  |
| d. <u>SIP Cerebellar bleed - 1991</u>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>N. Deshpande MD</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>46082</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>4/24/96</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. NEETA DESHPANDE FRANKLIN SQUARE   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 26 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Andrew Randall</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12499

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lila Vohra

2. Date of Death

Month Day Year  
April 27 1996

3. Time of Death

12:25pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-35-6602

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

8. Date of Birth (Month, Day, Year)

Dec. 5, 1923

9. Birthplace (State or Foreign Country)

Pakistan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6625 Corina Court

10f. Zip Code

21044

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Asian Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lal Chand Suri

18. Mother's Name (First, Middle, Maiden Surname)

Viran Wali Chaddha

19a. Informant's Name/Relationship (Type, Print)

Ramesh Khurana/son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6615 Corina Court Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 04/28/96

Data

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID J. JACKSON, MD 11055 Little Patuxent Parkway, Columbia, MD 21044

31. Date filed (Month, Day, Year)

APR 29 1996

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-8400.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



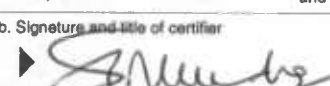
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 12500

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |  |  |  |   |  |  |
|--|---|---|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Florence A. Werner</b>                           |   |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 27, 1996</b>      |  | 3. Time of Death<br><b>18:05pm</b>                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Harbor Hospital Center</b> |   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>    |  | 4c. County of Death<br><b>N/A</b>                           |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-26-9268</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>September 12, 1930</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|  | Usual Residence of Decedent   |   |   |   |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore City</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>310 17th Avenue</b>   |   |   |   | 10f. Zip Code<br><b>21225</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>N/A</b>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ludwig Biedrzycki</b>  |   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Lillian Mazurek</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward J. Werner, Sr./Husband</b>   |   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>310 17th Avenue, Baltimore, Maryland 21225</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery, May, 01, 1996</b>           |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   |   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore, Maryland 21230</b>                |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SUSPECTED ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2-4 HOURS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |   |   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br> <b>ATTENDING</b>   |   |   |  | 29c. License number<br><b>D 21776</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 29, 1996</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURYA MUNDRA MD 203 E PATAPSCO AVE BALTIMORE 21245</b>  |   |   |   |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1996</b>  |   | 32. Registrar's Signature<br>  |   |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

This Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

